The Modern Hospital

NOVEMBER 1950

How the A. M. A. views hospital standardization • Metabolic laboratory at Wesley Hospital • Approach to the problem of long-term care • Primer of public relations • Costs of collegiate programs of nursing education • Activities of Blue Cross and hospitals

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The Modern Hospital

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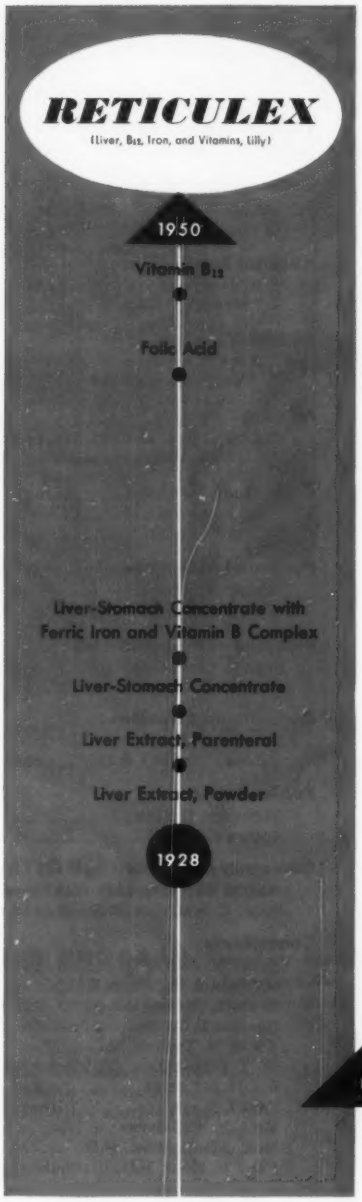

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AMONG THE AUTHORS


Bradford Ansley

Bradford D. Ansley is director of public information at Emory University, Atlanta, Ga., whose school of medicine and University Hospital serve a large area throughout the southeastern states. An experienced public relations man, Mr. Ansley is serving his second term as editor of the *College Public Relations Quarterly* and is a member of the executive committee of the American College Public Relations Association. A graduate of Emory himself, Mr. Ansley did radio work and served with a photographic unit in the navy before joining the Emory staff five years ago. His article on hospital public relations is on page 62.


Paul Bjerke

Paul G. Bjerke is pharmacist at the Luther Hospital, Eau Claire, Wis., a position he has occupied for the last eight years. A graduate of the University of Wisconsin, Mr. Bjerke served an internship in hospital pharmacy at the State of Wisconsin General Hospital, Madison, before taking over his duties at Eau Claire. He is a member of the Wisconsin Hospital Advisory Council, as a representative of the pharmacist group, and is chairman of the school of pharmacy and research committee of the Wisconsin Pharmaceutical Association. His article on hospital pharmacy operation appears on page 100 of this issue.


Clifford Sawyer

Clifford G. Sawyer, who writes about rates in small community hospitals on page 86 of this issue, is a member of the staff of the Commonwealth Fund in New York. A graduate of the Wharton School of Finance at the University of Pennsylvania and of the University of Chicago's graduate course in hospital administration, Mr. Sawyer served an administrative residency under the late Dr. Claude Munger at St. Luke's Hospital, New York, and has held a number of hospital positions, including those of administrator at a 125 bed hospital and personnel director at a 500 bed hospital. He also spent three years in the medical administrative corps of the army. The ideas presented in the article in this magazine were a part of the basic policy of the Commonwealth Fund's division of rural hospitals, Mr. Sawyer explains. After assisting in the establishment of some 15 rural hospitals, the division completed its operations last summer.


Dr. Morton Levin

As director of the Commission on Chronic Illness, the study group that has been established by the American Medical Association, American Hospital Association and other agencies to survey the nation's facilities for caring for the chronically ill, **Dr. Morton Levin** is on leave of absence from the New York State Health Department, which he serves as assistant commissioner for medical services. A graduate of Johns Hopkins University, Dr. Levin studied medicine at the University of Maryland, then returned to Hopkins for a degree in public health. Before joining the health department in New York, Dr .Levin was public health officer of Ottawa County, Michigan, associate physician at Rosswell Park Memorial Institute, Buffalo, N.Y., and associate director of the New York State Cancer Survey Commission. Dr. Levin has lectured on public health subjects at many of the nation's leading universities and medical schools. His article on the commission's program appears on page 55 of this magazine.

Reader Opinion

Costs of Indigent Care

Sirs:

I have studied Commissioner Hipple's article with considerable interest. In common with others in the welfare field who comment on this very pertinent subject of remuneration, he evades the fundamental issue, which, plainly and concisely is "Should the governmental agency pay full cost for the care of its clients or should it participate in the philanthropy of the community, past, present and future?" This is the real issue and no logical argument can be advanced to justify an agency's purchasing hospital care at less than cost.

Dr. Ginzberg's study and conclusions were based on an average of the hospitals in the state, and while it may be true that in some institutions a small percentage of their business is welfare there are many hospitals where this class of patient constitutes an appreciable percentage of the total. As a concrete example, General Hospital of Syracuse, without an ambulance, handles a very small percentage of indigent patients, whereas other, larger institutions carry a high percentage of the load. Therefore, although the indigent rate means little to me in dollars, I have always been fighting for actual cost because I thoroughly believe in the principle involved. Onondaga County has an enviable record of fair remuneration and fair play. I cannot say the same for many of our counties.

Naturally, I believe that the best approach of the hospitals in a given area is fair and honorable negotiation with the cards on the table. I do not believe in taking the position that our price is so much, take it or leave it; however, there have been occasions where the attitude of the welfare commissioner has forced the hospital to take an arbitrary stand.

The commissioner's statement that the hospitals gain when the infant days are adjusted to adult by dividing by four is not correct. A careful study in our county by the welfare auditor shows that the cost of the care of the newborn, under the new regulations set up by the state department of health, is approximately one-third the cost of the care of an adult.

The arbitrary statement that ward cost is 15 per cent less than average cost, formerly used in the formula, cannot be substantiated. As a matter of fact, experience teaches us that it costs more to take care of an indigent patient, on the average, than it does to take care of other hospital patients. The reasons for this are obvious: malnutrition, late hospitalization, and so on. In Syracuse we find that the length of stay of the indigent is much longer than the average. This would seem to prove our contention; at least, it convinced the committee of the board of supervisors, when I brought out the point and had it confirmed by the welfare auditor.

The argument that hospitals enjoy tax freedom is as old as the hills. The answer is that without tax exemption, which is provided in the Constitution, the cost would be higher and the welfare would bear the additional charge.

There are other statements in the commissioner's article which could be debated; however, in the main it is a

fair statement of the problem, from his point of view, and I congratulate him.

I hold no brief for extravagant management. The purchaser has the right to look at the goods and price before ordering and the welfare commissioner has power to protect his community from charges which cannot be justified. As I have always claimed, proper education of welfare officers and their supervisory bodies will solve the problem. I am perfectly willing to add hospital executives to that list.

CARL P. WRIGHT
General Hospital of Syracuse

Punch & Humor

Sirs:

I am writing to express my pleasure at the excellence of the Convention Digest. Such fine journalism renews expectations for hospital literature.

MARVIN LAWRENCE
The Jewish Hospital
Cincinnati

Sirs:

The MODERN HOSPITAL Convention Digest of 1950 is one of the most satisfactory reports of the national convention that I have ever read. It was not my privilege to attend this year, and your coverage was a satisfactory substitute. The Digest would be of particular interest to the directors of this hospital. . . .

WILSON E. TUCKER
Rochester General Hospital
Rochester, Pa.

Sirs:

A round of applause for your Digest. Most professional publications are "nice Nellies." They avoid taking a position on any matter and wind up being pretty dull. Your Digest not only tells the story of what happened at Atlantic City but does it with punch and humor and expresses your own views clearly. It was a pleasure to get a report of the convention so soon.

VICTOR KRAMER
New York City

Sirs:

Now The MODERN HOSPITAL comes up with the unique idea that sex determines whether or not an individual is a competent hospital administrator! Granted that some men administrators are doing superb jobs in high finance, broad community relations and personnel management—so are many women administrators. We also have some confused, misguided souls in the profession, but it doesn't necessarily follow that they have a Miss or Mrs. in front of their names. Be fair with the ladies! We don't ask for any special consideration; we just want to be judged by our abilities and by the accomplishments we have made in the hospital field.

E. K. LONGLEY
Paulina Stearns Hospital
Ludington, Mich.

Miss Longley and any others who thought the "Type V" story in the Convention Digest took a dig at women administrators should polish up their glasses and read it again.—ED.

Needs Back Copies

Sirs:

In checking our back copies of The MODERN HOSPITAL we find the following issues for 1946 are missing: February, March, April, May, July, September and October.

Will you please publish a request for these issues in the "Letters to the Editor" section.

ANN GRAY
Director of Public Relations
Aultman Hospital
Canton, Ohio

Roving Reporter

Mr. Gurney Takes a Wife

The British call their news "intelligence," and the little news organ issued regularly by Massachusetts General Hospital comes under the same sedate classification. Along with its scientific and personal news, the MGH publication dips frequently into its historical files. An example is the romantic interlude in the life of Supt. Nathan Gurney, revealed in two letters addressed to the hospital's trustees.

The first of these two letters bears the date of Feb. 20, 1830: It reads:

"Holding an Office under the authority of the Board of Trustees of an Institution which has been raised to its present elevated rank among similar Institutions in the Country, by the constant *care, watchfulness* and *exertion* of the board, every possible change in any of its internal arrangements may in some degree affect its interests. Having during the considerable time I have been connected with the Institution been treated by the Board with the greatest respect and kindness (for which I ask permission to tender my grateful acknowledgments) I however have it in contemplation to change my present situation, and to connect myself with a Lady of this City, and therefore deem it proper to make you acquainted with this intention and to request the favour of the Board that a Committee may be appointed, with whom I may confer, and learn their views, perhaps, better than by submitting any specific proposition."

The board was in no hurry to reply, so on March 21 Mr. Gurney was forced to submit a specific propostion, to wit:

"In a late communication, I intimated to the Board an intention of changing my present situation, and uniting myself with Mrs. Elizabeth Fennelly of this City. I was not so explicit in my views at that time, as I should have been, had there not been some uncertainty existing, whether she would be willing to reside in the Hospital, on account of the adverse opinion of some of her friends. Since that time, however, she has come to the conclusion that she is willing to remove there, and enter upon her duties of that situation, provided she has the approbation of the Board, the opinion of some of her friends to the contrary nothwithstanding.

"You will permit me, therefore, to enquire whether such a connection would be satisfactory to the Board, so far as the interests of the Hospital are concerned.

"If such a course does not comport with the views of the Trustees, it would be pleasant to me, if a verbal intimation could be given instead of spreading it upon the records."

Nothing was spread upon the records, and from reliable historical sources it appears that on March 21, 1830, a "gay scene—one seldom witnessed in a Hospital" took place. It was a wedding with House Physicians officiating as groomsmen and many patients present.

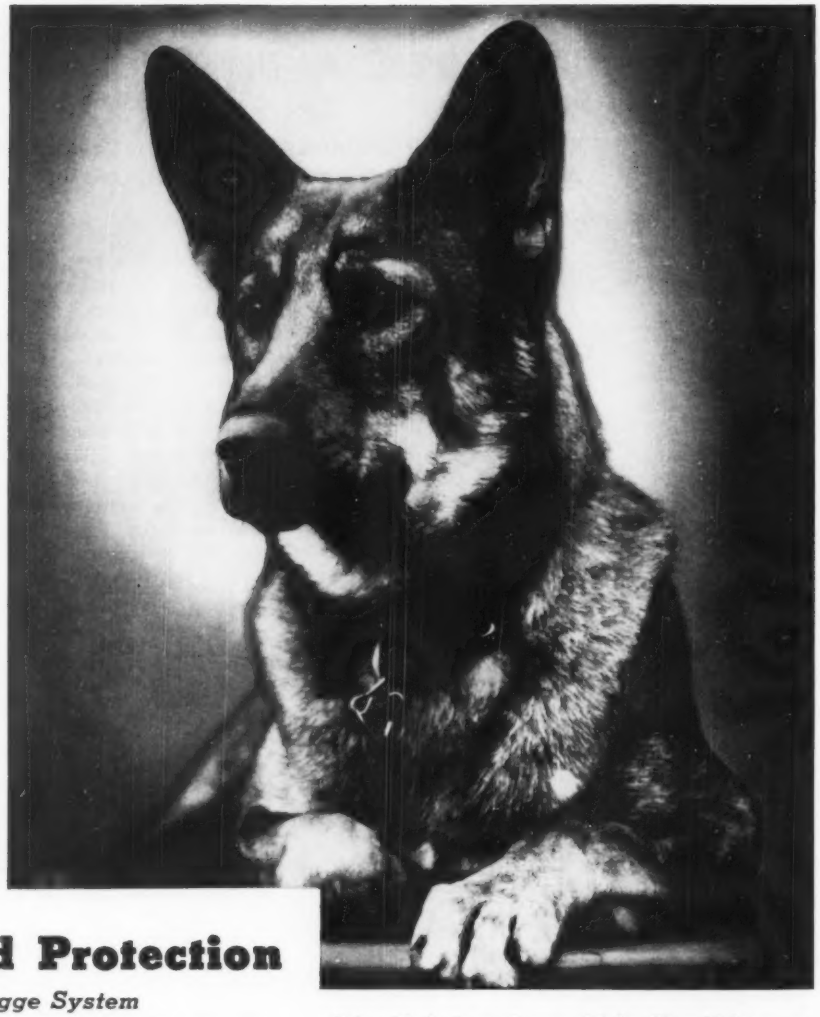
Smoother Road

Ashamed that he hadn't thought of it before, Dr. Robert H. Lowe says that the newly created post of director of employe-patient relations is paying "terrific dividends" at Rochester General Hospital, Rochester, N.Y. The job was created by the medical director at the beginning of the year.

Considering the position merely from the standpoint of the hospital guest, it is a wonder worker. The office of the director—who is a woman—is right next to the admitting office. Many new patients are terrified and their relatives are having a hard time keeping their own nerves under control. Suppose they have a pleasant and calm person to take them to their room, and answer the thousand and one questions that patients and relatives have. Immediately their fears are allayed and the rough road has been smoothed a bit.

The director, in her trips around the hospital, has many chances to answer patients' questions in regard to their bills, to create understanding in the minds of relatives of the seriously ill or the recently deceased, to explain why too many visitors have a bad effect, and to warn mothers not to bring their children sweets that make envious and unhappy other child patients on restricted diets.

When it comes to advising employes who drop in to talk over their gripes and problems, the director of employe-patient relations is equally useful.



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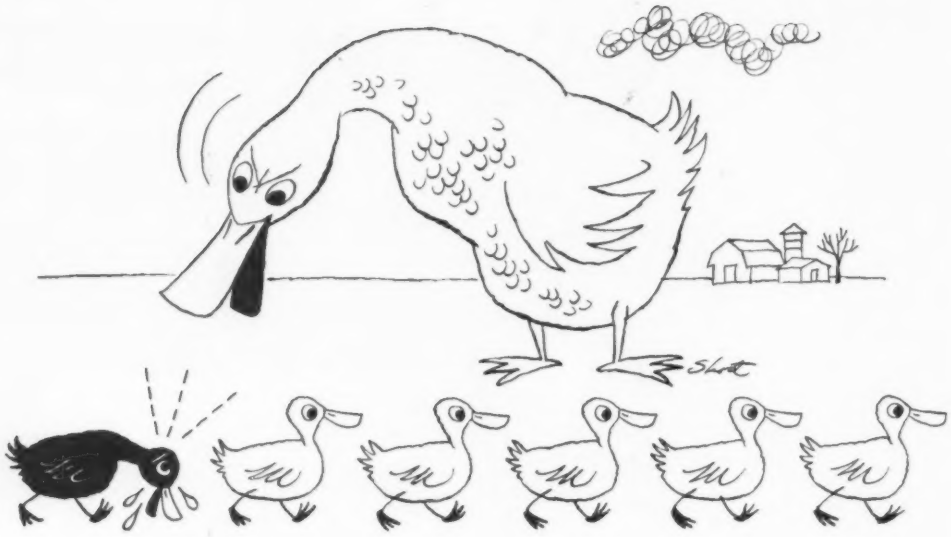

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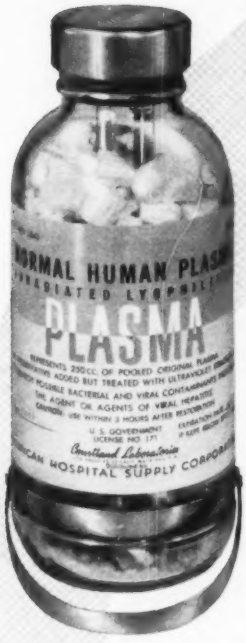

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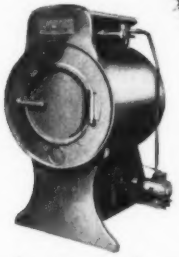

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HUEBSCH gas-heated TUMBLER

Ideal for small laundry installations or as an additional unit for extra capacity. Three sizes: 36" x 30", 36" x 24", 36" x 18". Low gas consumption. Fast drying. Trouble-free operation. Has all HUEBSCH design and construction advantages. Low cost.

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In planning the kitchen, the architects arranged the Gas Equipment so that food preparation could be carried out in assembly-line fashion, with many operations going on simultaneously. The method assures that serving deadlines will be met regardless of the occupancy of the hospital.

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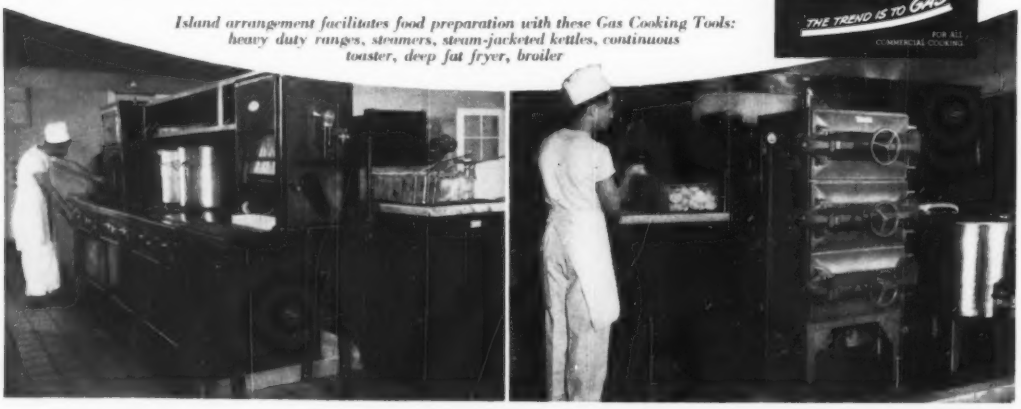

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Bananas... a natural sweetener

● **One medium-sized fully ripe banana (yellow peel flecked with brown) contains the equivalent of 4 to 5 level teaspoons natural sugar—as follows:**

Sugars in the Banana Total 20.4%
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3.6% levulose
12.2% sucrose

VITAMIN CONTENT PER 100 GRAMS

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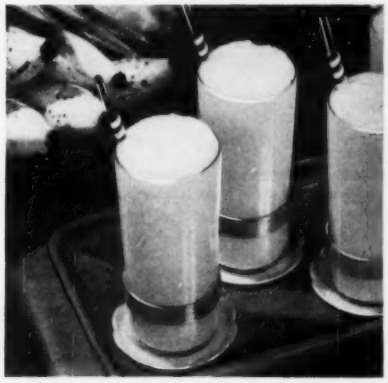
Niacin (Nicotinic Acid) . . . .6 Milligrams
C (Ascorbic Acid) . . . . . 10-11 Milligrams

Bananas Contain 11 Essential Minerals

SERVED ON CEREALS—Sweet and nutritious

ONE BANANA CONTAINS VITAMINS, MINERALS AND QUICK FOOD ENERGY



IN MILK SHAKES—For high caloric and high vitamin diets

Free Upon Request

Revised edition of
"DIETARY USES OF THE BANANA IN HEALTH & DISEASE,"
by L. Jean Bogert.

* * *

Educational Department 3
UNITED FRUIT COMPANY
Pier 3, North River, New York City

Banana Milk Shake

1 fully ripe banana* 1 cup (8 ounces) COLD milk

**Use fully ripe banana . . . peel well flecked with brown*

Peel banana. Slice into a bowl and beat with electric mixer or rotary egg beater until smooth and creamy. Add milk and mix thoroughly. Serve immediately.

Makes 1 large or 2 medium-sized drinks.

Banana Milk Shake is only one of the many new uses for Bananas.

For floors in step with modern practice...

Dr. E. V. Brown, of Caldwell, New Jersey, has a Nairn Linoleum floor that assures comfort, quiet, easy maintenance, and enduring beauty. Moderate in cost, Nairn Linoleum will give him long years of trouble-free service.

the 4-square features of Nairn Linoleum!

Long life, for years of trouble-free service. Enduring beauty, to keep your office looking fresh and smart. Easy maintenance, so your Nairn Linoleum floor will stay clean and sanitary with little effort—no cracks or crevices to harbor dirt and germs. And true resilience, for quiet and comfort underfoot. Where can these 4-square features of Nairn Linoleum be of greater value than in a busy doctor's office—*yours*, for example!

1. Long Life
2. Enduring Beauty
3. Easy Maintenance
4. True Resilience

NAIRN LINOLEUM for Floors and Walls

Trademark ®

For your requirements:
Nairn Linoleum
Nairn Wall Linoleum
Nairn Asphalt Tile
Congoleum-Nairn Inc.,
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Xavier Hospital, Dubuque, Iowa. Architects and engineers—Schmidt, Garden & Erikson, Chicago.

. . . high, too, in operating efficiency

"The patients in this hospital are benefiting from the very latest ideas in structural and operating efficiency." (From Hospital Management feature story about Xavier Hospital, Dubuque, Iowa.) Vital to this *operating efficiency:*

(1) **Edwards Nurses' Call System** insures immediate attention by registering above door, at nurses' stations and utility rooms.

(2) **Edwards Doctors' In and Out Register** immediately tells operator or receptionist who is in the hospital. Also, a flick of a switch at the operator's register causes an automatic flashing of the doctor's name as he checks in, thus informing him that there is a message waiting.

(3) **Edwards Synchromatic Clock System** for automatic split-second accuracy.

Yes, all signaling and call equipment complete to the most minute detail. It's no wonder that the personnel accomplish their multiple tasks with such ease and high efficiency. In these days of unprecedented demands on nurses and doctors, Edwards equipment is basic to the smooth, time-saving operation of Xavier—or any modernly equipped hospital.

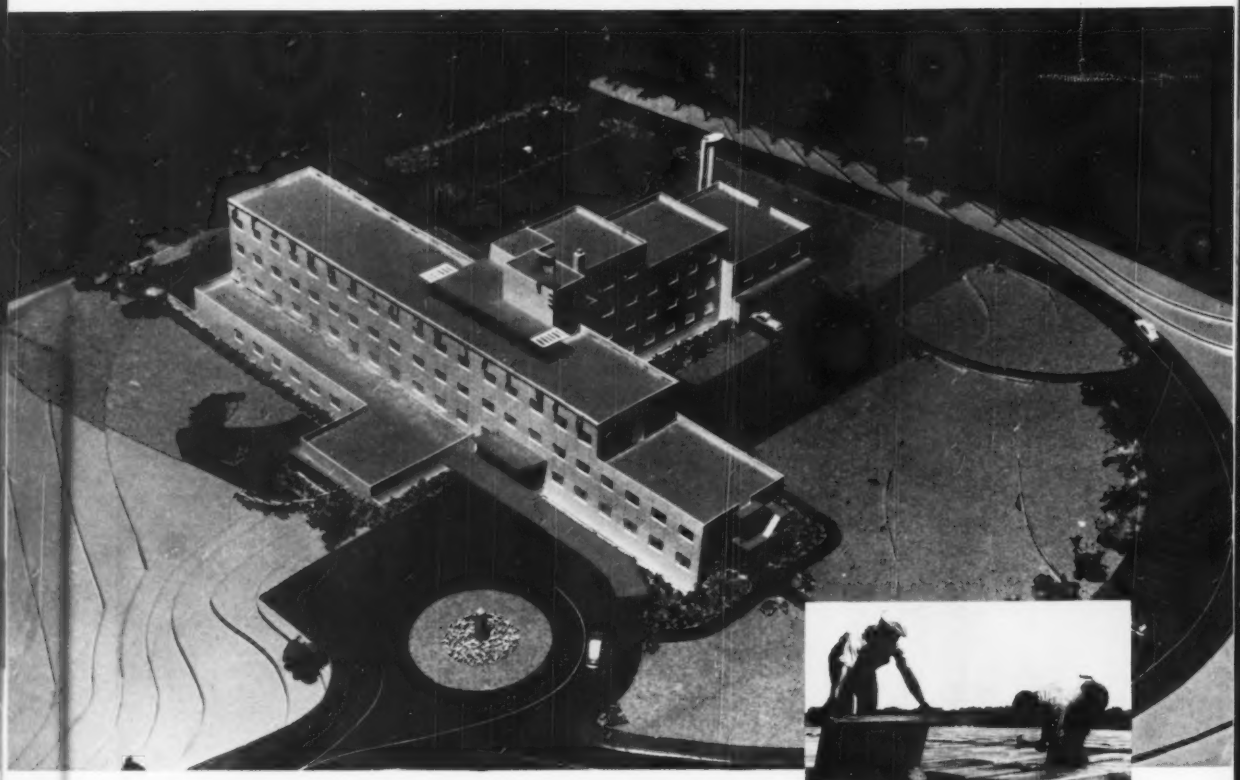
Write for illustrated bulletin on Edwards Hospital Signaling Systems.

EDWARDS

Hospital Signaling Systems

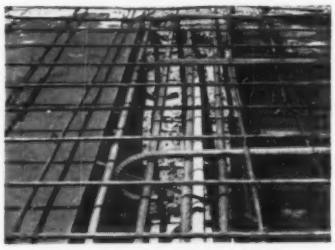
Edwards Company, Inc., Norwalk, Conn. *In Canada: Edwards of Canada, Ltd.*

Strong Enough to resist an *Earthquake*



Labor of placing and removing steelforms by skilled Ceco workmen is ordinarily included with the rental charge.

There's one word usually associated with hospitals—"QUIET." But there's another word that's equally important—"SAFETY"—and it covers every phase of hospital activity. So, when the Sequoia Hospital of Redwood, California was designed, extra consideration was given the matter of construction methods. Here's where Ceco Concrete Joist Construction met the need. It provides strong, rigid floor construction. Yes, construction strong enough to resist an earthquake—shockproof yet flexible enough to absorb great strain—safe again since it's fire resistive. And Ceco Concrete Joist Construction answers the need of "QUIET" in hospitals because it assures a soundproof building. All this is possible at definite savings—less labor, less concrete, less lumber. And since removable steelforms are used over and over again, from floor to floor, only a nominal rental is charged. As originator of the steelform method, Ceco is first in the field. So for concrete joist construction, call on Ceco, the leader over all.



Placement of Ceco reinforcing steel is detailed by our engineers and supervised by trained erection crews.

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Eye-let Ventilated Breathing-Border . . . Fine quality 8-ounce Tick Covering. . . .

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Please your coffee drinkers with America's *favorite* brand of coffee—*Maxwell House Coffee* (specially blended for institutions).

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Folks who can't drink coffee will be forever grateful if you provide them with *Instant Postum.*

Catch 'em all with G.F.'s

...AND MAKE TALK WORK FOR YOU!

Naturally folks are pleased when you serve their *favorite* foods and beverages. And just as naturally they'll tell their friends about your thoughtfulness. That's why it pays to serve brands you *know* folks will like. That means famous brands like Maxwell House Coffee, Jell-O Desserts, Log Cabin Syrup, Snider's Condiments and all the other General Foods Institution Products. The people you serve have enjoyed these wonderful products in their own homes for years. Contact your G.F. Man or Distributor for service. Or write: Institution Department, General Foods Corporation, 250 Park Ave., New York 17, N.Y.

PEOPLE WHO TALK ABOUT GOOD FOOD...TALK ABOUT

For those who prefer tea, serve *Maxwell House Tea*–the delicious, superbly blended, restaurant tea with the most famous name in hot beverages.

Many people find it hard to drink coffee and sleep. They appreciate decaffeinated *Instant Sanka*. That's why Sanka is the fifth largest-selling, nationally-advertised brand of coffee.

complete line of hot beverages

Find out the reasons people give for talking about your food service. Write for a summary of a survey of the public's attitudes toward eating out, prepared by the Opinion Research Corporation. Send a card to: General Foods Institution Food Service, 250 Park Ave., New York 17, N. Y.

GENERAL FOODS!

Products of General Foods

Ever hear of Noble Cowles' plan for anesthetizing hospital noise?

WHO'S Noble Cowles? He's the Gold Bond Acoustical expert at National Acoustics,* New York City. He's one of seventy-three factory appointed Gold Bond sound control engineers located in key cities across the country.

What's the Plan? It's a 2-Way Sound Control Plan—the most complete Sound Conditioning service you can get.

So if kitchen clatter, echoing halls and buzzing voices are an annoyance in your hospital call in your local Gold Bond Applicator today (listed in your phone book under "Acoustical Contractors".) Each one is an expert at de-noising hospitals in a hurry.

FOR FREE SOUND CONDITIONING ESTIMATE... PHONE YOUR LOCAL GOLD BOND APPLICATOR

Central Roofing Co.	*Abilene, Tex.*
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Braun Acoustical Co.	*Louisville, Ky.*
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Acoustical Contracting Co.	*Merrill, Wis.*
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Gold Bond Acoustical Co.	*Mobile, Ala.*
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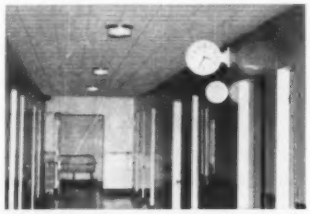
Here's how this 2-Way Sound Control Plan works:

1 EXPERT SERVICE AND INSTALLATION. Find the name of your local applicator in the list at left. He'll be glad to talk over your noise problem at no cost or obligation to you. He'll show you samples of all five Gold Bond acoustical products and tell you which is best for the job. And his expert, factory-trained crews will work at times most convenient to you.

BUSINESS AS USUAL. *Your Gold Bond Applicator will sound condition your hospital at times most convenient to you.*

2 FIVE PRODUCTS TO CHOOSE FROM. Every sound conditioning job has its own problems. Your hospital rooms and offices may have an unusual ceiling design. Or you may have very little money for modernizing purposes. That's why Gold Bond makes not one but *five different* Acoustical products to cover every possible need and meet any budget.



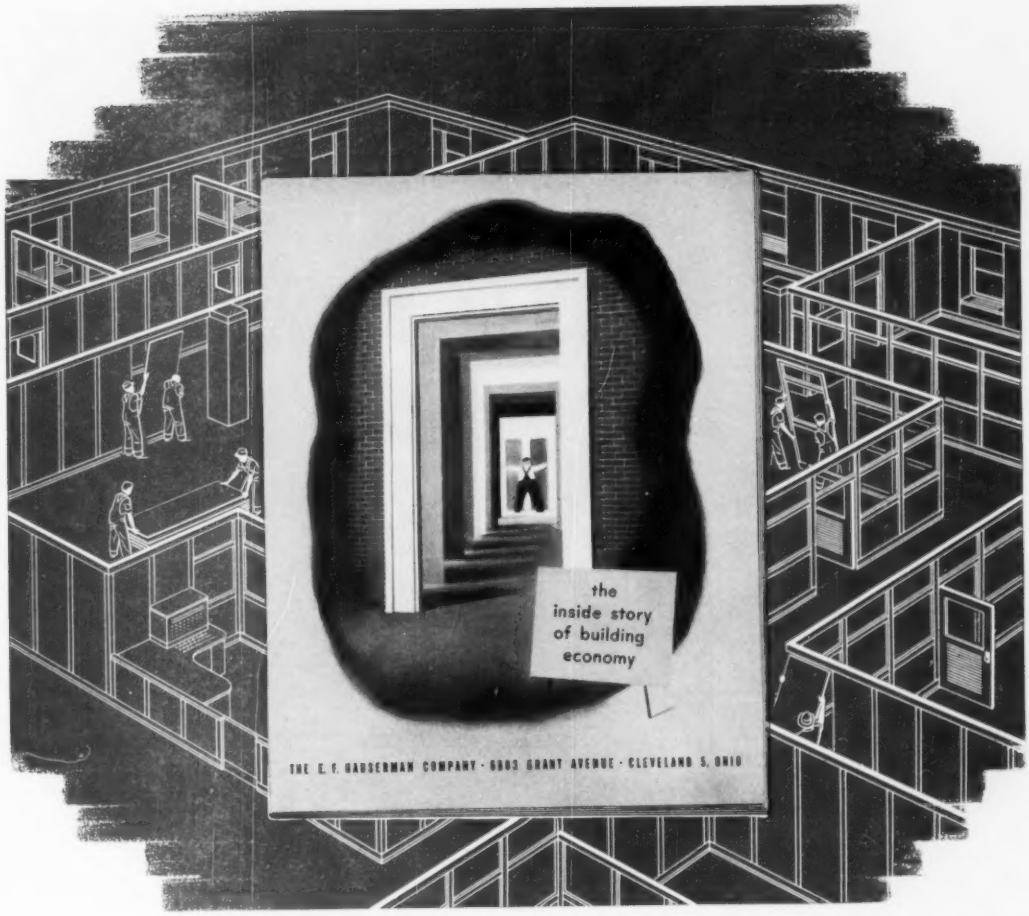
BEAUTIFUL RESULTS. *A big variety of washable and repaintable surfaces and colors, priced to fit your budget.*

PHONE FOR YOUR FREE SOUND CONDITIONING ESTIMATE NOW

Why put up with annoying hospital noise a day longer? Call the nearest Gold Bond Acoustical Applicator listed at left. Or write Department M-11, National Gypsum Company, Buffalo 2, New York.

You'll build or remodel better with Gold Bond Acoustical Products

NATIONAL GYPSUM COMPANY • BUFFALO 2, N. Y.



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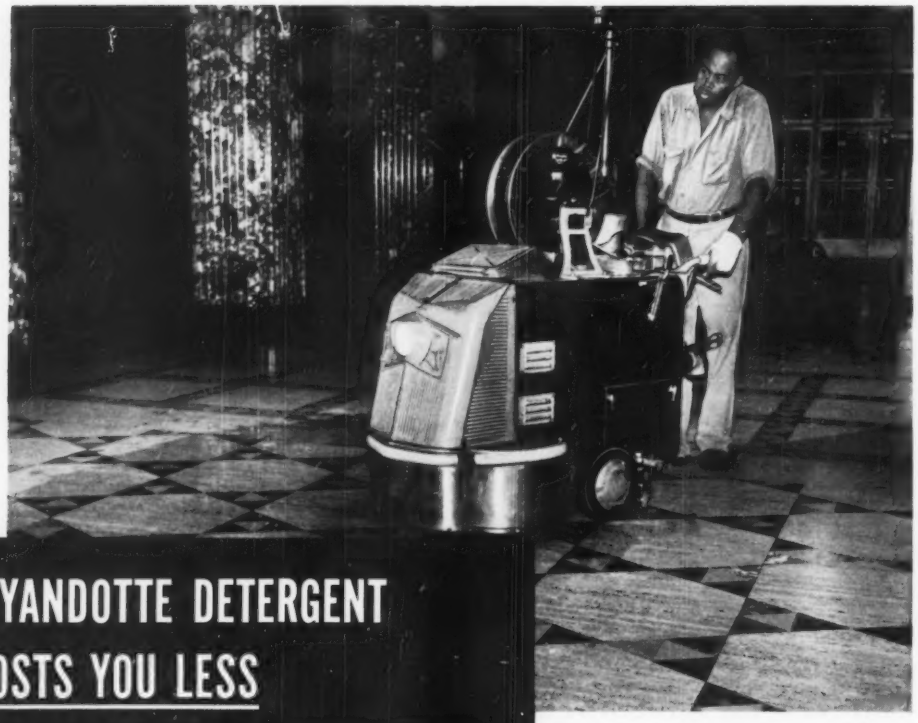

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DETERGENT

WYANDOTTE Detergent saves you money! And we've got the audited accounts of building managers all over the United States to prove it! One pound of Detergent cleans more floor (or wall) space, in less time, with less harm to mops and brushes . . . than any other cleaning material.

And the big reason is Wyandotte *pumicite!* This unique volcanic ash is found *only* in the Wyandotte mines in Norton, Kansas. To our knowledge, *there is no other source* of this perfect pumicite.

Perfect? Well, Wyandotte pumicite is hard enough to cut dirt — too soft to scratch paint. The large, flat flakes "get under" the dirt, lift it off. And they're easy to "pick up." You get this perfect abrasive only in Wyandotte Detergent. Ask your Wyandotte Representative or Supplier to show you a photomicrograph of Wyandotte pumicite. It will prove our point.

- Contains exclusive pumicite
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- Eliminates slipping accidents
- Rinses freely — leaves no alkali
- Will not harm tile, terrazzo, mosaic, marble or wood
- Will not harm brushes or mops
- Takes less labor to "pick up"
- Costs less per square foot per year

THE WYANDOTTE LINE—***floor and wall cleaners:*** Detergent, F-100; ***marble cleaner and poultice:*** Detergent; ***tile and porcelain cleaners:*** Detergent, F-100, Paydet; ***cement cleaner:*** El-Bee; ***floor wax:*** Anti-Slip Wax; ***germicides and sanitizers:*** Steri-Chlor, Spartec—**in fact, specialized products for every cleaning need.**

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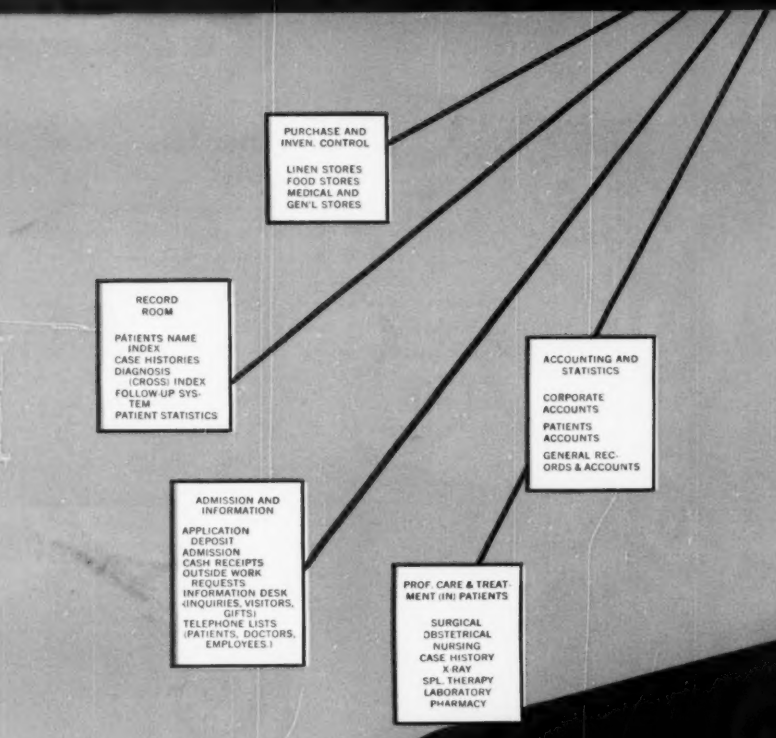
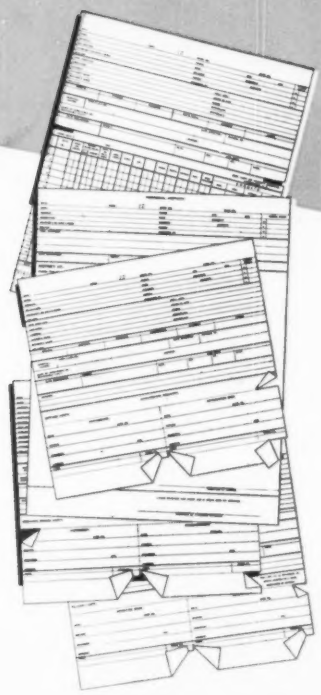


dozens of ways to

Simplify and Save

With Remington Rand Patient Record Systems and Equipment



Speed Up Admission Procedure With Multiple-Copy Forms... Tailored to Your Needs

1 Admission Record
2 Switchboard Copy
3 Information Desk Copy
4 Personal History
5 Ledger
6 Record Room Copy
7 Interne's Record
8 Floor Copy
9 Operating Room Copy
10 An Extra Copy
11 Admitting Office Copy

Here's a way you can save work and be sure of getting every patient off to a good start with complete, accurate, legible records. With Remington Rand's special combination form, you can prepare all 11 records (or whatever number you require) *in one single writing.*

No re-copying of data from one form to another, no chance of errors or omissions. Another advantage – records frequently referred to are designed for convenient filing in Kardex cabinets or handy book units. Visible signals provide effective control.

Free folder *describes use of multiple-copy admission forms at Emergency Hospital, Buffalo, N. Y. Use coupon on Page "D".*

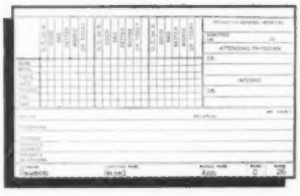
What Beds Available? Kardex Tells You at a Glance

Many hospitals file their permanent room and ward bed records numerically in Kardex Book Units for convenient desk use. Forms have a cut-out in the visible margin so that when the Admitting Office Copy of a new patient's record is inserted, the patient's name shows through, indicating that that particular room or bed is occupied. Margins with no name showing indicate – graphically – what space is available. Expected date of patient's release may be signaled on the margin, as a further aid to the Admitting Clerk in making advance reservations.

Free folder *describes the highly efficient record control systems used by Mercy Hospital of Portland, Me. To get your copy, use coupon on Page "D"*

Simplify and Save *with*

REMINGTON RAND PATIENT RECORD SYSTEMS AND EQUIPMENT

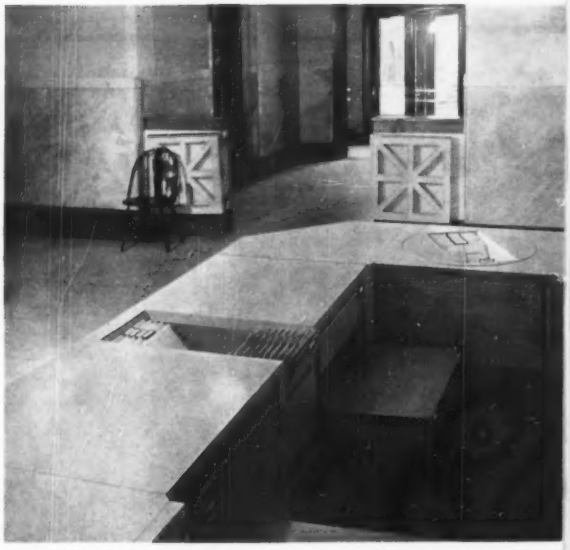


The Information Desk copy of the manifold patient record form is designed for filing in Kardex visible equipment—either book unit or cabinet.

Information? Here's An Ideal Arrangement

The Information Desk pictured here, at St. Mary's Hospital in Detroit, has two indices sunk flush with the counter. The one in the revolving well contains a separate, visibly indexed pocket for each doctor, where he checks himself in and out and receives call notices, letters, etc. The other index, with pocket for each patient, provides convenient control over visitors through use of guest cards issued from and returned to this file.

Free folder *illustrates typical items in Remington Rand's functional "Trend" furniture line. Use coupon on Page "D".*



Use Time-Saving, Space-Saving Systems In Your Record Room

Remington Rand offers a full range of filing systems and supplies for efficient filing and finding of all patient data housed in your record room. Expert advice on time-saving, space-saving techniques is yours, without obligation.

Shown here is a part of an Aristocrat 5-drawer file installation which enabled one hospital to relieve an extremely crowded condition. These files provide easy access to 25% more records in the same space previously occupied by 4-drawer files. The Aristocrat line also includes numerous card files and substitute drawers, permitting you to "tailor" your filing space to fit your needs economically.

Free folder *"How to Save Space..." shows the finest, most economical 5-drawer files obtainable today. Use coupon on Page "D".*

Crowded for Space? File Your Inactive Records on Film

On one small roll of microfilm you can store complete records of as many as 175 patients. In one film file no larger than a standard filing cabinet you can store some 300,000 records! These are the space savings you can achieve — at surprisingly low cost — with Remington Rand Film-a-record. Also, with Microdex indexing, you can have high speed reference and positive assurance against loss, misfiling or alteration of records.

You may buy or lease a Film-a-record camera, or have us copy your records, on a contract basis, on our own machines. Either way you'll profit by our long experience, coast to coast, in meeting hospital requirements.

Free folder *tells how two typical hospitals save filing space through use of Film-a-record. See coupon on Page "D".*

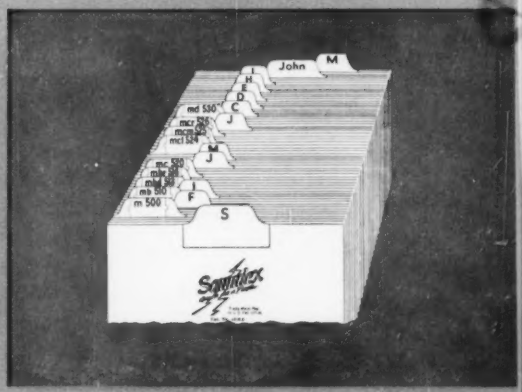
Don't Worry About the Spelling — Find Names by SOUND

Burke? Bourke? Burk? Berk? Beurck?

Like many other names, "Burke" can be spelled a dozen ways. Yet, when the Doctor calls for a Patient's History Record, he *always* wants the right record and usually *right away.*

SOUNDEX, incomparably faster and more accurate than alphabetical filing, is the answer to this need. It's very simple — a method that groups names by *sound.* Soundex — like other Remington Rand systems — can be set up for you, ready to use, by our installation experts without disturbing your routines.

Free folder *outlines the amazing features of the Soundex system for filing by sound. Use coupon on Page "D".*



Two Basic Ways to Cut the Cost of Handling Hospital Accounts Receivable

One! Remington Rand's FOREMOST Accounting Machine, enables you to post statement, ledger and journal *simultaneously* with each line of posting automatically proved. Same machine can be quickly adapted, by the operator, to other jobs such as accounts payable and payroll.

Two! Kolect-A-Matic, the simplified accounts receivable system, saves time and work in manual *or* mechanized accounting; provides a visibly indexed account "pocket" for each patient, for convenient housing of charge slips until posted and graphic signaling of account status to guide and speed collection efforts.

Free folder *describing the features of the "Foremost" Accounting Machine will be furnished on request. Use coupon below.*

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Thousands of libraries – including those in many of the nation's leading hospitals—agree that Library Bureau quality is true economy when it comes to buying furniture, systems, or supplies. One convenient source, Remington Rand, brings you anything or everything your library needs, whether it's a catalog card tray, book case or posture chair.

Free folder *illustrates principal items in the wide selection of Library Bureau Trend Furniture for hospital libraries and other hospital departments. Use coupon below.*

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Management Controls Reference Library, Room 1506-A, 315 Fourth Ave., New York 10, N.Y.

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Please furnish free literature, without obligation.

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- ☐ Patient History Records (SN572)
- ☐ Space-saving 5-drawer files (LBV 465)
- ☐ Film-a-record Equipment (SN 722)
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- ☐ Soundex Filing System (LBV 528)
- ☐ Accounting Machines (AB 392)

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CANADIAN HEAD OFFICE, TORONTO 1, ONTARIO

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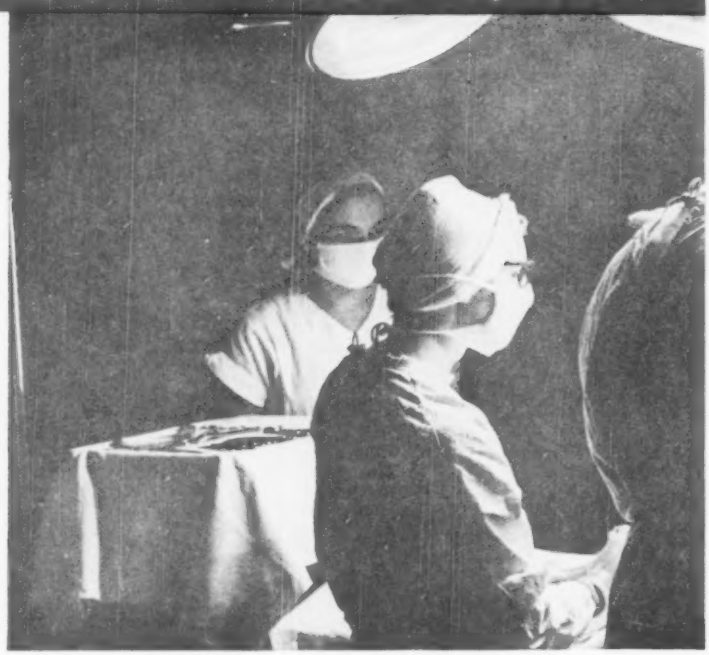

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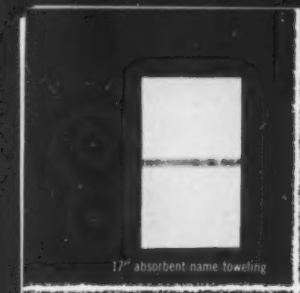
FACTS FEW HOSPITALS CAN OVERLOOK . . .

Regular use of the AMPIN in a 728 bed hospital would create a potential saving of 7,213 nursing hours in a period of a year, according to the findings of the first Time and Motion Study* ever made in a hospital. These figures are based on scientific, clock-watch observation of more than 2000 injections. The figures gained from this study showed that the cost of the AMPIN, in terms of original investment, operational costs and time consumed, was far less than any other method. With the AMPIN, the purchase cost is the only cost, while, with other injection methods, according to these findings, all other costs often exceed the purchase cost.

THOUSANDS OF DOLLARS SAVED

In terms of a full year's use of the AMPIN in the 728 bed hospital making the study, the use of the AMPIN would have saved from $26,090.49 in the case of Multiple Dose Vial injections to some $36,710.24 in the case of hypodermic tablet medication. Of high importance is the fact that the saving increases as the cost of the medication increases.



17" absorbent name toweling

22 x 44 heavy terry towel

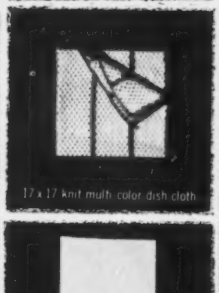
Huck name hand towel

Heavy terry bath mat

14 x 20 colored huck hand towel

17 x 32 satin border huck towel

Fine quality huck name towel



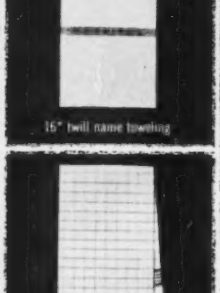
17 x 17 knit multi-color dish cloth

14 x 20 fine huck towel

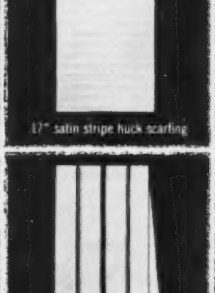
12 x 12 name face cloth

12 x 12 color-border face cloth

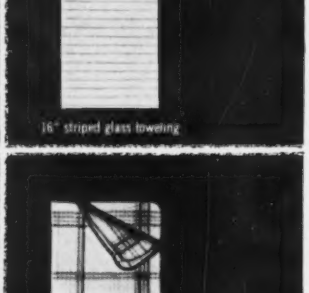
16" huck name toweling



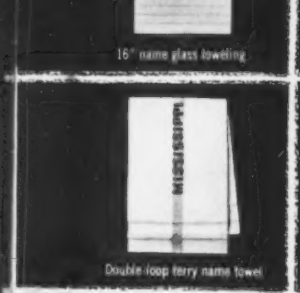
16" twill name toweling



17" satin stripe huck scarfing



16" striped glass toweling

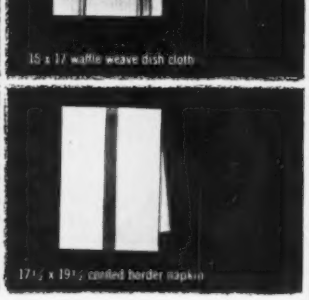


16" name glass toweling

17" striped crash toweling

16 x 32 check dish towel

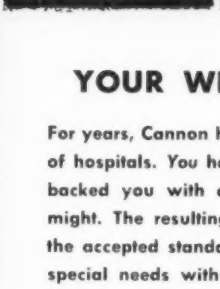
17 x 32 multi-color dish towel



15 x 17 waffle weave dish cloth

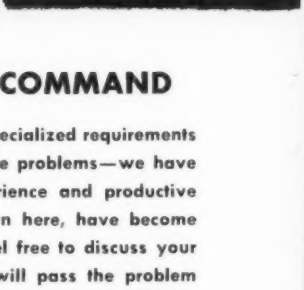
Double-loop terry name towel

Multi-color pot holder



Jacquard napkin (pattern)

Jacquard napkin (pattern)



17½ x 19½ corded border napkin

Popular weight, popular price Cannon terry bath towel (20"x 40"). Style 2906

YOUR WISH IS OUR COMMAND

For years, Cannon has responded to the specialized requirements of hospitals. You have come forth with the problems—we have backed you with all our technical experience and productive might. The resulting Cannon items, shown here, have become the accepted standard of the industry. Feel free to discuss your special needs with your distributor. He will pass the problem along to us. Cannon Mills, Inc., 70 Worth St., New York City 13.

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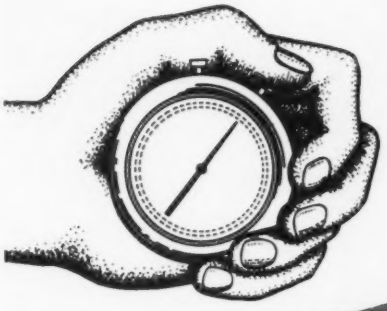

WHEN SECONDS COUNT . . .

USE

MICHAEL REESE

Irradiated Liquid

NORMAL HUMAN PLASMA

IRRADIATED LIQUID NORMAL HUMAN PLASMA:	
Plain, undiluted, 600 cc.	**$36.00**
Plain, undiluted, 300 cc.	**19.80**
300 cc., diluted with 250 cc. Isotonic solution of Sodium Chloride	**19.80**
Pediatric Size, 60 cc.	**4.80**
IRRADIATED DRIED NORMAL HUMAN PLASMA:	
Dried, 300 cc.	**$19.80**

LIQUID PLASMA

now carries a two-year dating.

Outdated plasma is returnable for replacement at no charge.

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	SIZE	PRICE
Anti-A and Anti-B Blood Grouping serum,	2cc	$ 2.00 per set
Anti-A and Anti-B Blood Grouping serum,	5cc	$ 4.50 per set
Anti-Rh$_0$ Typing serum, slide test	2cc	$ 3.00 per vial
Anti-Rh$_0$ Typing serum, slide test	5cc	$ 7.50 per vial
Anti-Rh$_0$ Typing serum, saline tube test,	2cc	$ 3.00 per vial
Anti-Rh$_0$ Typing serum, saline tube test,	5cc	$ 7.50 per vial
Anti-Rh$_0$' Typing serum, slide test,	2cc	$ 3.00 per vial
Anti-Rh$_0$' Typing serum, slide test,	5cc	$ 7.50 per vial
Anti-Rh$_0$' Typing serum, saline tube test,	2cc	$ 3.00 per vial
Anti-Rh$_0$' Typing serum, saline tube test,	5cc	$ 7.50 per vial
Anti-rh' Typing serum, saline tube test,	1cc	$ 3.50 per vial
Anti-hr' Typing serum, slide test,	1cc	$ 3.50 per vial
Anti-Rh$_0$rh'rh" Typing serum, slide test,	2cc	$ 4.00 per vial
View Box for Rh slide test		$20.00 per box

Special discount available to yearly contract buyers.

INSTITUTIONAL PRODUCTS CORPORATION

161 SIXTH AVENUE • NEW YORK 13, N. Y.

Trane Convectors are an ideal source of heat to supplement the humidified, tempered ventilation air which is normally specified for modern operating rooms.

Correct heating

Trane Convector Heating is being specified more and more every day to effectively meet rigid hospital requirements for healthful, dependable, economical heat because—

Efficient Trane Convectors spread comfortable warmth throughout each room—quickly—uniformly from floor to ceiling. Cool air is drawn in below the convector, instantly warmed by the compact heating element and then distributed to even the remotest corners of the room—gently and without danger of drafts.

Rooms are cleaner—*hospital* clean—because convector heat is cleaner heat. Modern Trane Convectors are designed to eliminate inaccessible points where dirt and dust collect.

Trane Convectors fit snugly out of the way under windows. They can be painted to harmonize with any scheme of decoration—adding a note of cheery comfort to each room. They can be installed free standing, wall hung, semi-recessed or completely recessed into the wall.

Economical too! Because Trane Convectors come in a wide range of types and sizes to fit any steam or hot water system. They cost less to install, cost less to maintain. No heat is wasted because convector heat is steady—even—controlled heat.

The Trane sales engineer in your area will be glad to work with your architect, engineer or contractor to help solve your heating, ventilating or air conditioning problems.

THE TRANE COMPANY...LA CROSSE, WIS.

EASTERN MANUFACTURING DIVISION, SCRANTON, PA.

Manufacturing Engineers of Heating, Ventilating and Air Conditioning Equipment—Unit Heaters, Convector-radiators, Heating and Cooling Coils, Fans, Compressors, Air Conditioners, Unit Ventilators, Special Heat Exchange Equipment, Steam and Hot Water Heating Specialties ... IN CANADA, TRANE COMPANY OF CANADA, LTD., TORONTO.

Trane Convectors fit every application perfectly, providing the utmost in healthful, comfortable heat.

Congratulations!

to Masonic Home, Zenith, Wash.,

on its Compact, Highly Efficient, Laundry Department

All linens, blankets, curtains, etc., are laundered in this compact laundry consisting of 2-Roll STREAMLINE Flatwork Ironer, ZONE-AIR Drying Tumbler, Solid Curb Extractor, 25-lb. and 50-lb. CASCADE End-Loading Washers.

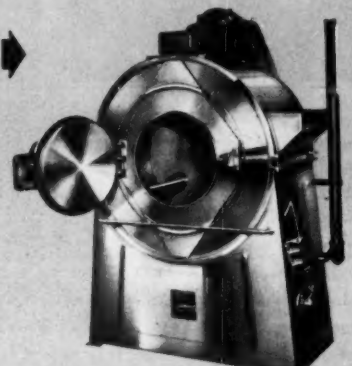
PROBLEM: This Masonic Home, which cares for 160 elderly persons, questioned whether its clean linen problem was being handled most efficiently and economically.

SOLUTION: Our Laundry Advisor was requested to make a thorough study and submit all findings. His report listed actual benefits to be obtained by installation of a small, efficiently equipped laundry department. Masonic Home then decided to install the laundry according to specifications supplied by the Laundry Advisor.

RESULTS: The Superintendent reports savings of $833 during first 3 months of operation. Other benefits include "better quality work", "faster return of linens to service" and "smaller linen inventory."

Hospitals, large or small, are invited to discuss their laundry problems with our Laundry Advisor. No obligation. WRITE TODAY.

CASCADE End-Loading Washer. **Masonic Home uses two of these late-type washers, one 50-lb., one 25-lb. dry wt. capacity. Famous *CASCADE through-and-through washing action* gently, yet thoroughly, washes linens sterile-clean with amazing economy. Washers feature extremely simple operation; are sturdily constructed of Monel metal for dependable service.**

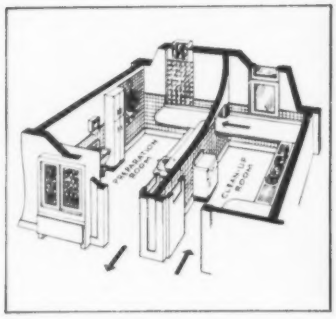


Your hospital will benefit by selecting from our complete line of most advanced and productive hospital laundry equipment.

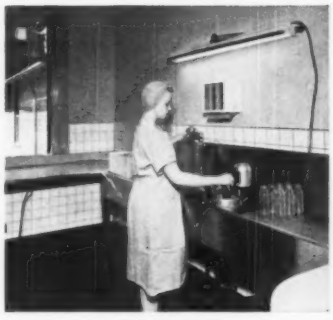
REMEMBER . . .
Every department of the hospital depends on the laundry!

The
AMERICAN
LAUNDRY MACHINERY CO.
CINCINNATI 12, OHIO

Safe, simple preparation of milk formula



This carefully planned work flow production line saves time and steps in formula preparation.



Washing room. Only clean technique must be observed here since bottle, nipple and cap will be subject to terminal heating as final step.

Formula room. The entire product—formula, bottle, nipple and nipple cap are placed in the autoclave for terminal heating at 230°F. for 10 minutes.

Parents, in this case, see the care that is taken to protect their infant. Note the refrigerator on left. It is filled from the Formula room and is accessible from corridor.

Rectangular autoclave for large volume. Cylindrical and rectangular autoclaves available for capacity from 32 to 384 bottles per load.

Mobile bottle warmer—for transportation of bottles to the nursery. Warms bottles to 102°F.

Bottles, nipples, and nipple caps are washed clean. The entire assembly of bottle, formula, nipple, and nipple cap . . . all in place . . . is placed in the sterilizer chamber. It is heated at 230°F. for 10 minutes.

It is as simple as that—and no amount of elaboration will improve the end result.

Hospitals throughout the country have found this simple technique completely safe and satisfactory.

For experienced help in improving your formula preparation facilities see your Castle dealer or write: Wilmot Castle Company, 1175 University Ave., Rochester 7, N. Y.

Castle **LIGHTS AND STERILIZERS**

The Inside Also Needs Quiet!

NOISE in the hospital is irritating to patients and will actually retard recovery. Many noises cannot be avoided in the operation of a hospital, but these noises *can* and *should* be reduced as much as possible before they reach the patients. The clean round drilled holes in Simpson Acoustical Tile absorbs unwanted noises. A Simpson installation is permanent, washable and paintable. Usually, Simpson sound conditioning can be installed in existing hospitals with little or no interruption in service.

Simpson Acoustical Tile . . . and *only* Simpson Acoustical Tile offers ALL five features listed at the right. These desirable features add up to one BIG reason . . . "MORE FOR YOUR MONEY". This is the reason more and more architects and hospital officials are calling for Simpson Acoustical Tile.

ONLY SIMPSON HAS ALL FIVE!

1. WASHABLE FINISH
2. HIGHER SOUND ABSORPTION
3. HOLLOKORE DRILLED PERFORATIONS
4. FINISHED BEVELS
5. MORE BEAUTIFUL AND EFFICIENT

Simpson QUALITY SINCE 1895 **ACOUSTICAL TILE**

FOR BETTER SOUND CONDITIONING

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HEINZ SOUP SERVICE

14 KINDS OF HEINZ SOUPS IN 51-OZ. TINS

Cream of Tomato • Bean • Split Pea
Genuine Turtle
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Vegetable Without Meat • Vegetable
Beef Noodle • Beef With Vegetable
Chicken Noodle
Chicken With Rice • Clam Chowder
Cream of Mushroom
Cream of Chicken

Makes 20 five-ounce or 17 six-ounce servings.

Provides Convenience and Economy For Schools, Hospitals, Sanitariums and Other Institutions

HEINZ SOUPS in institution-size, 51-oz. tins give important advantages in economy and convenience that will prove as helpful to you as to thousands who are using this modern soup service! These delicious Heinz Soups enable you to serve without waste, more varieties than would otherwise be possible.

- **The 14 kinds** available in institutional-size tins cover approximately 90% of demand and afford a service that is ideal for every quantity-type operation. They economize on help and assure accurate control of costs.
- **Most important** of all, Heinz Soups are extra nourishing and have the lure of "home-cookin'" flavor that appeals to all appetites. Your Heinz man will gladly show you the money-saving advantages in serving delicious Heinz Soups.

Ask Your Heinz Man About

HEINZ 57 SOUPS

How much pen-work, Doctor?

Every time you use a pen to inscribe the day-by-day facts of your practice, Doctor, you impose upon yourself and your work a needless, *costly* and *time-consuming* drain.

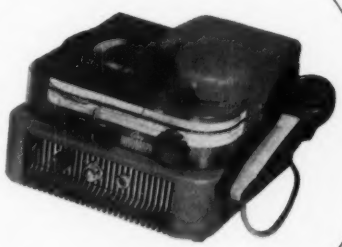
The AUDOGRAPH Soundwriter will relieve you of this in a way that is quick, convenient and economical of your *time* and *money*. For the AUDOGRAPH records *all the facts* . . . patient interviews, diagnoses, post-surgical notes and instructions, laboratory findings . . . and, of course, your routine correspondence and the preparation of medical papers. AUDOGRAPH will even record your important *telephone calls*.

For the full facts . . . just how AUDOGRAPH will save time, eliminate laborious handwritten notes, free you for the essentials of your busy practice . . . mail the coupon *today!* You'll save yourself time and money, and streamline your record-keeping in one simple move.

The "Master" AUDOGRAPH: the ideal combination dictating and transcribing machine. Records on thin, lightweight, long-lasting plastic discs holding up to *one hour's dictation*. Will operate wherever electric current is available.

Made by The Gray Manufacturing Company—established 1891—originators of the Telephone Pay Station.

Dictation is EASIER



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ELECTRONIC SOUNDWRITER

AUDOGRAPH sales and service in 180 principal cities of the U.S. See your Classified Telephone Directory—under "Dictating Machines." Canada: Northern Electric Company, Ltd., sole authorized agents for the Dominion. Overseas: Westrex Corporation (export affiliate of Western Electric Export Company) in 35 foreign countries.

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These new *EXTRA*-fast-setting bandages—latest addition to the "Specialist"* family of plaster-of-Paris products—will save time and eliminate irksome waiting for plaster to set in club-foot, wrist, ankle and other small casts. Order now through your dealer or write us for FREE trial supply.

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PLASTER OF PARIS

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NEW BRUNSWICK, N. J.

Small Hospital Questions

Safety in the Surgery

Question: Is it necessary to have an explosionproof operating room light?—A.H., B.C.

ANSWER: The new standards on hazardous locations where explosive anesthetic gases are used have been set forth in a new pamphlet published by the National Fire Protective Association. These standards were arrived at jointly by a committee representing the N.F.P.A. and the American Hospital Association. Any electrical fixture or outlet which is above the 5 foot level from the floor does not have to be explosionproof. Anything beneath this level must be explosionproof whether it is a light or an electrical fixture or outlet. You should obtain the N.F.P.A. pamphlet from either the National Fire Protective Association or the American Hospital Association and study it carefully.

Standardization Possible

Question: Is standardization of drugs, supplies and so forth possible within the small hospital? Is it desirable?—E.A., Minn.

ANSWER: Definitely. A great deal of standardization and simplification can be done even in small hospitals. In the case of drugs and pharmaceuticals it is difficult to work out unless the administration can obtain the full cooperation of a special formulary committee of the attending staff. The whole problem is simplified if the hospital has a full-time, well prepared pharmacist. Hospitals of even 100 beds can effect some genuine economies by appointment of a capable pharmacist. Not only can this pharmacist work with a drug or formulary committee of the staff to reduce the inventory carried and at the same time improve drug therapy, but he can often take charge of routine purchasing and the storeroom.

The American Hospital Association's committee on purchasing, simplification and standardization has, in cooperation with the National Bureau of Standards and manufacturers, developed a large number of simplified practice recommendations and commercial standards reports. The reader can obtain a list of these by referring to the editorial reference section of the *Hospital Purchasing File*. The 28th (1950-51) edition will contain the annual article on simplification and standardization and, in addition, will give digests of some of the more important simplified practice recommendations and commercial standards. Some worth-while economies can be made in hospitals of any size by a sensible simplification and standardization program.

Wood or Steel Furniture?

Question: Is wood or steel furniture preferable for a patient's room?—A.M.L., Ill.

ANSWER: I don't believe there is any definite answer to this question. The answer depends entirely upon the preference of the group picking the furniture. Either wood furniture with the special finish which has been developed by companies making wood furniture for the hospital field, or steel furniture developed particularly for hospital use is entirely satisfactory and will give fine service.

Machines Are Economical

Question: To what extent have small hospitals employed business office machines? Is this an innovation or have only the larger (200 beds and up) hospitals been able to employ time-saving devices?—H.P.M., Mo.

ANSWER: Many small hospitals have begun to use various types of posting machines to post patients' accounts and to control accounts receivable. In addition to this, the manufacturers of business machines have developed smaller inexpensive machines for use in the business office for handling accounts payable, pay rolls and for posting expense charges to the regular A.H.A. chart of accounts. Adding and calculating machines are, of course, regularly used in small hospitals. There is great advantage to the small hospital in using these mechanical business machines. More accurate work is done and more nearly complete and better management control reports can be issued each month with fewer personnel hours than are needed to get inadequate reports out by the old hand methods.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Steam Preferred

Question: Is it preferable to have sterilizers heated by steam, gas or electricity?—H.H., Wash.

ANSWER: If high-pressure steam is available most authorities agree that steam is the best medium to use in sterilizers. However, in some hospitals where there are no high-pressure boilers, electrically heated sterilizers are very satisfactory. By and large it is better to stay away from gas for this type of equipment.

Budget for Nursing

Question: We recently heard the statement that nursing service salaries usually amount to 60 per cent of total hospital salaries. Is this statement true, and can you give us an authority for it? Also, can you tell us whether or not salaries for physical therapists, medical social workers, and dietitians should be included in the nursing service budget?—Sr. E., La.

ANSWER: Salaries and wages for nursing service will usually represent anywhere from 40 to 60 per cent of total hospital salaries, depending on conditions in the individual hospital. It is impossible to make a specific statement as to the actual percentage because conditions vary so much from hospital to hospital.

Of course, too, it makes a great deal of difference whether the value of maintenance in the form of meals, laundry and room is included when these are given to nurses as part of their total salary. The most advanced and best accounting procedures in hospitals include the total value of maintenance plus cash as the total salary received by any employe in any department.

Physical therapists', medical social workers' and dietitians' salaries definitely should not be included in the nursing service budget.—E. W. JONES.

THE ARMSTRONG X-4 BABY INCUBATOR IS STILL LOW IN COST STILL LOW IN OPERATING COST

THE GORDON ARMSTRONG COMPANY, INC.

To Hospital Administrators:

ABOUT PRICES

I'm writing you this memo October 9th to appear in all of our November advertising. By the time you read it anything can have happened but regardless of conditions in November our basic thinking will be the same. We shall fight against any increase in our selling price. This goes for any product we design and sell and applies particularly to the Armstrong X-4 Baby Incubator.

For 7 years now we have done this and in 7 years we have increased our Baby Incubator price less than 3 and ½ per cent and we have sold over 12,000 Baby Incubators. That's a record we're proud of. We shall keep on fighting costs.

Here is our pledge to you. We will not increase the price of the Armstrong X-4 Baby Incubator except as a last resort. As time goes on we may be forced to because we simply can't help it but we do not see it yet and we shall continue to fight against it.

Don't be "panicked" into buying anything. Don't order Armstrong X-4 Baby Incubators just because some other prices are going up. When you need Baby Incubators then buy an Armstrong X-4 because the price is low, because it is so easy to operate, because it is simple and safe and because back of every Armstrong X-4 Baby Incubator is 12,000 Incubators worth of experience.

We're both washing our necks in the same bucket you know—we're in this fight together. You can help us win by continuing to give us your loyalty and support just as you have for the past 7 years. Trust us to do our part.

Sincerely yours,

The Gordon Armstrong Company, Inc.

Gordon Armstrong

Gordon Armstrong
Pres-Treas

WHEN the Armstrong X-4 Baby Incubator was designed, we worked to keep both costs low for Armstrong X-4 users.

Low *first* cost has been accomplished by the elimination of unnecessary selling expense. Savings we have made in selling costs are passed along to X-4 users by holding down the price. As a matter of fact our price has increased less than 4% in seven years.

Low *operating* cost is accomplished through clean, simple design and easy control, with replacement parts for those that wear out in normal use available at low prices.

But these factors do not mean that the X-4 is cheap in *any* sense. All important construction materials and controls used throughout the X-4 are the finest on the market.

So, remember, the first cost on an X-4 is low, the operating cost is low. As long as it is humanly possible, we intend to keep it that way, as the users of over 12,000 Armstrong X-4 Incubators will tell you. Write for a complete description of the X-4 and you'll quickly realize why.

ACCEPTED COUNCIL ON PHYSICAL MEDICINE AMERICAN MEDICAL ASSOCIATION

C.S.A. APPROVAL NO. 7307

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Division DD-1 Bulkley Building, Cleveland 15, Ohio

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"Back of every Armstrong X-4 Baby Incubator is over 12,000 incubators' worth of experience."

Looking Forward

Real Third Party

AN OPINION delivered recently by the attorney general of West Virginia declares that "a hospital which employs a licensed physician on a salary and includes medical services performed by him as an item of expense on bills to its patients . . . is engaged in the unauthorized practice of medicine within the meaning of that term as defined by law in this state."

Granted that this opinion may be right under law, will its effect on doctors, hospitals and their patients be good or bad?

The traditions having to do with "corporate practice" originated in the close personal relationship between the physician and his patient. The physician's feeling of personal responsibility for the patient's welfare is rooted in this relationship, which is rightly regarded as precious. Essentially, the laws about corporate practice represent an effort to protect the patient-physician relationship against the intrusion of an impersonal third party—a circumstance which it was feared might dilute and perhaps eventually destroy the personal bond.

Many people today think that the hospital has become or is becoming such a feared third party. Plainly, this is the thinking that lies behind the opinion of the attorney general of West Virginia, the American Medical Association's resolution on hospitals and the practice of medicine, and other similar expressions which have emerged in recent years. Obviously it is possible to believe that the introduction of the hospital as a frequent third party to the patient-physician relationship is the corporate intrusion that was feared. The same situation, however, must also be recognized as the inevitable result of an advancing medical technology and its accompanying economic complications. The shift in emphasis in medical care from the patient's home and the doctor's office to the hospital has come about not because anybody particularly wanted it but because nobody could possibly prevent it. You can't put a betatron in a little black bag.

The original aim of protecting the patient will not now be served if the commendable effort to preserve the spirit of the patient-physician relationship turns aside from its purpose to hamper the normal operation of a third party which is there by reason of unavoidable scientific and economic circumstance. Instead, the effort must be, and certainly in many hospitals it has been, to achieve a cooperative approach that will focus all the apparatus and energies required in modern medicine on the care of the patient—at the least possible sacrifice of close personal contact and person-to-person responsibility.

While they are unquestionably aimed at protecting patient welfare, statements and opinions like that of the attorney general of West Virginia do not help to achieve this result. Neither laws nor resolutions will alter the central fact of the complicated relationship of doctor, patient and hospital today: The real third party is science.

Worth Knowing

IN CONSIDERING the case of a Washington, D.C., proprietary school of practical nursing against which a complaint has been issued, the Federal Trade Commission must decide whether the school's advertising to prospective students did or did not include "false, misleading and deceptive statements." Whether it did or not, evidence introduced at hearings on the case disclosed some disturbing facts about the operation of the school—and nursing authorities have pointed out that this one is by no means the worst of its kind.

At the school charged with false advertising, it was revealed, students received two hours of instruction twice a week for a period of six months—a total of 104 hours, for which they paid $169.50 (a higher rate per hour of instruction, incidentally, than most college students are required to pay). The quality of the instruction was in dispute during the hearings, but school authorities acknowledged that students practiced nursing procedures on one another and on dummy patients and were graduated without ever working with actual patients. Testifying for the school, a Washington nursing executive denied that hospital experience was essential in the training of practical nurses or that there was any difference between a practical nurse and a nurse's aide.

The commission has not yet decided whether the school's advertising was fraudulent, but the evidence

presented at the hearings should certainly convince hospitals everywhere of the need for carefully investigating the qualifications of candidates for employment in nursing positions. Short course and correspondence school nurses may be capable and conscientious, and they may provide Heaven-sent help to relieve the shortage of nursing personnel, but prudent hospital and nursing executives will ask for details about their training before assigning them to duty on hospital floors. A lot has been said on both sides of the practical nurse licensure question; whatever its complications and shortcomings as a solution to nursing problems, licensure would at least provide a means of distinguishing girls who have given a hypodermic from those who haven't. In the hospital, that's worth knowing.

House of Mercy

HOSPITAL people should take steps to persuade moving picture exhibitors in their communities to show the new R.K.O.-Pathé documentary film, "House of Mercy." As administrators who saw the picture during the convention at Atlantic City discovered, it is first-rate hospital publicity.

"House of Mercy" was made in a hospital (at Princeton, N.J.), not in a studio. With one or two exceptions its people are hospital people, not actors. The narrator is a pleasant man with a story to tell, and not a huckster type with a sale to make. There is no hoked-up melodrama here, no phony attempt to portray hospital men and women as heroes and angels. Instead, it is a calm story of earnest people doing useful work whose importance to the community is often overlooked.

Especially good are realistic scenes showing beds crowded into corridors and nurses living in cramped, shabby quarters—scenes that would have been omitted from the usual propaganda picture aimed at glorifying everybody and everything. There are one or two slips (the average small community hospital, which this is supposed to represent, doesn't have its own ambulance service, for example), but on the whole this is a picture that hospital people can bring to their communities without apology or embarrassment. Those who do will benefit. In the long run, the most powerful of all propaganda is the truth.

Reverse Trend

AS OPPOSED to 36 per cent three years ago, 47 per cent of medical students in the class of 1949-50 were planning to enter general practice, according to a survey reported last month by the Council on Medical Education and Hospitals of the American Medical Association. The number of students planning to specialize decreased from 36 to 31 per cent in the same period, the report indicated. The survey covered 31 classes in 19 medical schools.

Obviously, several factors have been at work to bring about this shift in interest. The council report indicates that many schools have established programs designed specifically to stimulate interest in general practice. Affiliated hospitals in some of the schools have developed internships and residencies planned for prospective general practitioners. Certainly the general practice sections on hospital staffs have had some influence on medical students, and the programs and publications of the American Academy of General Practice have added interest.

These are all sound developments, and it is heartening to learn that they are having the desired effect of braking the trend toward overspecialization that might eventually have left serious gaps in the nation's medical care system. If it could be done, it would be interesting now to analyze student opinion in detail in an effort to determine the comparative importance of the various factors that influenced the student's decision on a professional career. One guess is that personal contact with teachers in medical schools and hospitals would be found the strongest factor, and gold medals and publicity gimmicks about the good old family doctor would be the weakest.

Standardization

IN THE president's report published prior to the annual convention of the American Hospital Association, and in the report presented to the convention by the special committee that had been studying the problem for the board of trustees, the association's interests in hospital standardization were clearly set forth. So that the position of the American Medical Association on this important subject might also be brought before the hospital group, The MODERN HOSPITAL asked Dr. George F. Lull, secretary and general manager of the American Medical Association, to summarize recent discussions on standardization and state the views of the medical profession. In response to this invitation, Dr. Lull has written the statement that appears on the following page for readers of The MODERN HOSPITAL.

As this magazine was being printed, the following statement was released by the American College of Surgeons from Boston, where the clinical congress of the college was in session:

"At their meeting today in the Hotel Statler, the Regents of the American College of Surgeons voted unanimously to continue the hospital standardization program of the college.

"Since the inauguration of this program in 1916, the college has expended more than $2 million in improvement of patient care in the hospitals of the United States and Canada. This money has been contributed almost exclusively by the surgeons of these two countries who are fellows of the college, and this program has been a major factor in the great improvement in health which has taken place in the last 30 years.

"A spokesman for the Regents stated that this action does not necessarily preclude consideration of proposals for the participation of other interested agencies in this program, but does make it clear that the American College of Surgeons has an undiminished interest in it and will consider no proposal which will not insure its continuation in the best interests of the public."

HOSPITAL STANDARDIZATION

SINCE 1918 the American College of Surgeons, without assistance from other organizations within the profession, has sponsored a hospital standardization program, the purpose of which was "to create in the hospital an environment which will assure the best possible care of the patient." It has been recognized by the medical profession and hospital group alike that the College of Surgeons through this program has made a significant contribution to American medicine and to the field of hospital administration as well. The cost of the program to date has been estimated at approximately $2,000,000, a financial burden which has been borne solely by fellows of the college.

Recently, the American College of Surgeons explored the possibility of conducting the program in cooperation with or by other interested organizations. The American Hospital Association expressed its interest in assuming responsibility for the program under its own aegis, and at its recent annual meeting in Atlantic City authorized an increase in dues of member hospitals for this purpose. A plan had been proposed which would create a 25 member commission within the American Hospital Association to include six members of the medical profession, six hospital administrators and 13 individuals with outstanding records as hospital trustees. The six-man medical committee was to have included three representatives of the American College of Surgeons and three of the American College of Physicians. To this committee was delegated the responsibility for formulating standards for those aspects of the hospitals' activities which were considered to be primarily of a professional nature. The determination as to which areas were primarily professional and which were administrative was, however, made the responsibility of the commission as a whole.

The American Medical Association, being of the opinion that a program of hospital standardization, such as had been proposed, would directly affect standards of medical practice in hospitals, requested that action by the American Hospital Association in establishing the standardization program be delayed until all aspects of the problem could be given careful consideration. Acting through its board of trustees, the association entered into discussion with the American College of Surgeons and the American Hospital Association in the hope that a cooperative plan could be developed which would eliminate a dual standardization program with its consequent duplication of effort and needless expenditure of funds.

The three groups have been holding meetings, the last of which was also attended by representatives of the American College of Physicians, in an attempt to clarify the position of the several organizations involved. Much progress has been made in working toward the objective, a plan in which the best interest of the public, the hospitals and the profession are all considered. There has been no disagreement over the principle that the setting of standards for the professional aspect of the hospital would lie with members of the medical profession. The American Medical Association has not felt, however, that this principle was adequately safeguarded under the plan originally proposed, which would set up a commission as an agency of the American Hospital Association.

As expressed in discussions held during the past several weeks, the American Medical Association is prepared at this time to consider favorably one of the following alternate plans:

1. Continued sponsorship of the hospital standardization program by the American College of Surgeons, with financial support by the American Medical Association and other organizations directly concerned.

2. Establishment of an individual commission, board or committee, with representatives from the American College of Surgeons, American College of Physicians, American Hospital Association and the American Medical Association, which would be charged with the responsibility of formulating standards for administrative and professional aspects of hospital activities, for conducting a unified inspection program for approval of hospitals which meet these standards; the financing of the cost of the commission, including the field inspecting service, would be borne on a proportionate basis by member organizations.

3. Transfer of the standardization program to the Council on Medical Education and Hospitals of the American Medical Association, with a unified inspection program conducted in connection with the field service now administered by the council in the approval of hospitals for intern and resident training. (In general surgery the council presently conducts hospital surveys in behalf of the American College of Surgeons, the American Board of Surgery and the A.M.A.)

Pending outcome of present negotiations, we have been advised that the American College of Surgeons will continue its present program.

It is our hope that the program so successfully carried out by the college over the last 30 years can be expanded under a plan acceptable to all organizations concerned, and that such a program will prove even more effective in bringing about the results toward which the several organizations are striving, that of better patient care.—GEORGE F. LULL, M.D.

The dietitian carefully weighs the prescribed food for each patient. Remaining morsels on the trays are weighed back and calculated; equivalent weight is incorporated in the next meal.

METABOLIC LABORATORY

helps to solve another health problem

RALPH M. HUESTON
Superintendent, Wesley Memorial Hospital, Chicago

IN RECENT years there has been an increasing interest on the part of scientists and the public in metabolic diseases. This interest has undoubtedly been stimulated by the much publicized dramatic effects of cortisone and ACTH on the human body. Because any successful attempt to study the harmful as well as beneficial results of such drugs depends upon maintaining carefully controlled research on human beings, Wesley Memorial Hospital, Chicago, has created an actual working partnership with medical science.

Wesley recently established a completely equipped metabolic laboratory, or kitchen, for this type of work, which will accommodate a maximum of six patients. The first of its kind in the Chicago area operated in conjunction with Northwestern University Medical School, the laboratory was made possible through the efforts of a retired Chicago executive, who was one of the first patients at Wesley to receive treatment with ACTH. The fund will be used to help finance the expense involved in maintaining a full-time dietitian, a part-time dietitian, a full-time cook and a relief cook. Additional personnel includes two full-time graduate nurses, one resident physician who will be on a part-time schedule, and two laboratory technicians at Northwestern's research laboratory.

It was decided that absolute accuracy and control of a few subjects closely grouped would yield more significant data than would a less rigid control of a large number of scattered patients. To further the independent unit idea, a suite of rooms at the end of a corridor on one of the medical floors was selected. As reassigned to accommodate the new research service, this suite now consists of one former two-bed room now converted into the metabolic kitchen, one 2 bed room for male patients, one 2 bed room for female patients, two private rooms and one utility room with the corridor partitioned to create an office for the dietitian.

Equipment includes a fabricated, stainless metal three-compartment sink, a table cabinet with a two-drawer food warmer, two tables, wall cabinets, and a range canopy. There are a disposal unit for the sink, a 15.4 cubic foot refrigerator with a 1½ cubic foot freezing space, an 8 cubic foot deep-freeze cabinet, a hot water booster, and an electric range with four surface units and two ovens. The hospital maintenance department installed the equipment.

A complete and separate metabolic unit with nurses and dietitians near at hand has further advantages, for patients are less likely to feel lonely and discouraged. Such a unit is conducive to a more contented "family" atmosphere which is essential for morale when patients must live restricted, regulated lives for a seemingly lengthy period. It is best that they do not observe the menu of regular hospital trays for those whose food is different and does not have to be consumed to the last crumb every day.

ENCOURAGES TEAMWORK

Such an independent unit encourages the spirit of teamwork in scientific experiment, not only in the doctors, nurses, dietitians and technicians, but in the patients as well. They are made to feel that they have the starring rôle in the drama, the success of which depends on their cooperation.

Inasmuch as the basis of these metabolic studies is the scientific preparation of prescribed food, the rôle of the dietitian is highly important. She must calculate a diet for each patient which not only will fulfill the requirements of the experiment, but will contain the kind and amounts of food which he will be willing to eat over a long period of time. The food must be accurately weighed on balance scales and then prepared with as much variety as can be obtained without sacri-

Right: Closeup of the stainless metal metabolic kitchen recently installed at Wesley Memorial Hospital, Chicago, to further study of ACTH. Below: Plan of the independent unit, which provides space for six patients.

ficing economy. If any of the food is not eaten, it must be weighed back and the equivalent weight incorporated in a later meal. The validity of the data is nullified if the patient does not eat the entire diet each day.

As far as possible, one particular brand of food, such as a variety of frozen vegetables from the same packer, is used for a three-month period. This guarantees that a certain patient will be given the same quality of food to eliminate variation of brands. Meats must not deviate from a specified cut; if veal shoulder is ordered, it cannot be substituted by veal thigh or rump. All baking, too, must be accomplished in the metabolic kitchen. All supplies, however, are ordered through the hospital.

UNIT IS ESSENTIAL

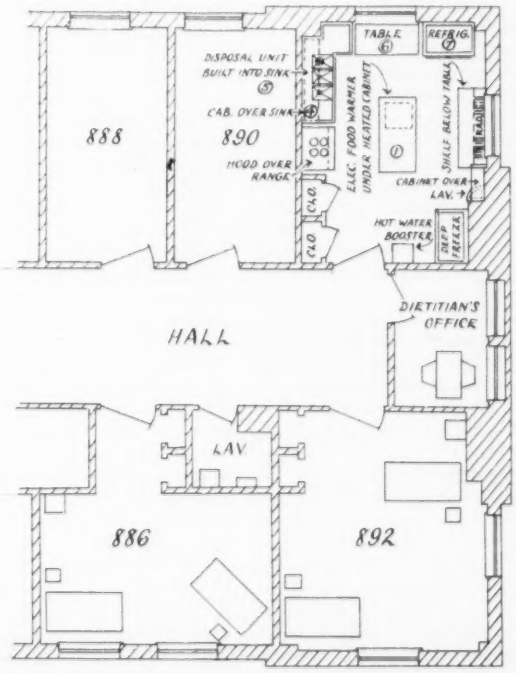
Dr. Smith Freeman, professor of experimental medicine at Northwestern University, is in charge of research conducted in the unit. Dr. Freeman feels that since little is known about the effects of ACTH on the patient's metabolism, it is important to learn as much as possible in every instance, and that for careful studies of this sort a metabolic unit is essential. Up to this time there had been a few metabolic beds but no metabolic unit in any of the Chicago hospitals affiliated with Northwestern University.

With Wesley's establishment of such a unit, Dr. Freeman said that it is "a real step forward, an additional facility of extreme importance which will prove to be a real asset in medical research at Wesley. It is an important asset not only as a research opportunity but in teaching medical students and residents as well. It will enable the hospital and medical school staff to carry out numerous clinical studies under more nearly ideal circumstances and will permit the student to gain first-hand experience with a technic of investigation that promises to become extremely common in the future."

Wesley's executive dietitian is charged with the over-all responsibility in seeing that the management of the metabolic laboratory is carried out as outlined by the research laboratory of Northwestern University. She is responsible for the maintenance of the staff and must be assured that the proper personnel is on duty at all times.

Operation of the kitchen of the unit is in direct charge of the full-time dietitian. She holds a master of science degree in foods and nutrition and has done much research on diets.

While the initial studies will concern the effects of ACTH on body metabolism, Dr. Freeman hopes eventually to expand the research to include work on calcium, sodium and potas-



sium balances. Also in the future are studies in low and high salt diets and specific food nutrients.

From the initial gift of $20,000, Wesley Memorial Hospital used approximately $7500 for the installation of the metabolic laboratory. The remainder of the funds will be used to help finance operating costs and the salaries of the personnel assigned to the research program.

It is estimated that the cost of special personnel to maintain the metabolic laboratory and to carry on the technical part of this research program will be approximately $32,000 a year.

Considering the fact that the diet must be *constant* day after day, sometimes for a period of months, it takes the human body several days to reach an equilibrium and produce a steady excretion. This period of adjustment works to the advantage of our dietitian because it allows her time to discover which foods a patient will eat and the amount he likes. The staff handling the metabolic patients knows that the choice of food and amounts is vitally important at the outset, for once the study starts there is no opportunity to change a single item as it all must be consumed. Every patient is encouraged to send his dishes back to the kitchen looking as if they had been "licked."

Our dietitians realize the advantage in giving the patient just a little less food than he thinks he wants at first. Thus, he will not be tempted to leave anything on his tray, and furthermore he will probably tire of the same food every day and it may become increasingly difficult for him to consume it "to the last crumb." Before many days of this routine pass, he will appreciate having to eat less.

The metabolic kitchen at Wesley is equipped to handle calls for food at any time of the day. This is vitally necessary because certain patients may require feeding of smaller amounts at frequent intervals. This is especially common in patients who are suffering from nausea and vomiting because of x-ray sickness or for some other reason. If there is vomitus, it is saved, analyzed in the laboratory and subtracted from the intake.

MUST COAX THEM TO EAT

However appetizing our special cooks make the servings, some patients find it impossible to eat all the food. The nurse on duty will attempt to coax the patient into eating all the serving rather than just a little. In the latter instance the dietitian will have her problem in calculating, by weighing back the amount left over. This is difficult considering the weight loss or gain in cooking. However, if one item alone has not been touched, the dietitian knows exactly how much to subtract from the theoretical intake.

The establishment of a complete metabolic laboratory in a hospital is, to those connected with it, a fascinating adventure in the field of research dietetics, although it is time-consuming and scrupulous in detail. It is a field replete with hard work and discouragement at times, but it also has romance, promise and much satisfaction.

COURTESY is a special project

ROBERT LEBIN
Employment Supervisor

STEPHEN MANHEIMER, M.D.
Director
Mount Sinai Hospital, Chicago

RECOGNIZING the obvious importance of courteous behavior, the administration of Mount Sinai Hospital, Chicago, classifies courtesy instruction as a special and separate employe training project. The subject was explored at one of the regular monthly meetings of the department heads and further discussed at subsequent meetings.

A courtesy committee was appointed to study the project. At first the committee was unanimously opposed to contests and popularity selection as tools. This type of approach was regarded as superficial and of negligible value. Instead, stress was placed on an evaluation of attitudes of which courtesy is a by-product. Employe behavior, as influenced by relations between employes and supervisors, and patients and employes, was considered of primary importance.

However, final action included a multi-pronged attack on the problem, and both direct and indirect methods of stimulating courteous behavior were used. A series of talks was arranged. A staff neuropsychiatrist presented the subject of courtesy, as an aspect of mental hygiene, to our department heads and nurse supervisors. He referred to courtesy as a way of living which cannot be merely demanded but which must be practiced a great deal in order to become a part of the personality. He explained the origin of the word and traced it back to early civilization when courteous behavior implied, "I am unarmed, I am not hostile, I have no animosity toward you." At a later date, an outstanding person in the hospital field was invited to address the group. He emphasized the importance of displaying understanding and appreciation to employes by the supervisors. He made it clear that employes' needs must be respected and the importance and dignity of each job, no matter how remote from actual patient service, be stressed. Articles on the subject of courtesy have been printed in *Today*, our employes' magazine.

Employes were invited to write essays on the subject, "What Is Courtesy?" and were told that as a reward the winning essay would be published in our house organ together with the name and photograph of the author. Response to our essay contest and to our courtesy slogan contest was good. The essay chosen as best was submitted by a young woman who cleans and sterilizes glassware in our laboratory.

Her essay stated: "Courtesy means more than mere politeness or service indifferently rendered. Real courtesy is not forced but comes from one's innermost soul. Courtesy means nothing when given with a meaningless smile or as a sense of duty or obligation. Real honest courtesy comes from the heart and bubbles forth as easily and naturally as a spring of cool water. The receiver of courtesy glows with happiness and immediately proceeds to be courteous so as to make others happy, too." The winning courtesy slogan, submitted by another employe, declared: "Courtesy is consideration of others."

Methods of attempting to increase courtesy are numerous. By continually emphasizing the concept in various ways we hope that both patients and employes will derive benefit.

Architect's rendering of the Home for the Jewish Aged, Kansas City, Mo., designed by Kivett and Myers. It will provide complete institutional service in pleasant, informal surroundings and will give residents the feeling of being at home.

an approach to the problem of LONG-TERM CARE

MORTON L. LEVIN, M.D.
Staff Director
Commission on Chronic Illness
Chicago

THERE are many chronically ill people now being cared for in their own homes by their families who for the sake of both the patient and his family would be better handled by some medical institution. There are also many who cannot be cared for in their own homes. A few of these people are now in special chronic disease hospitals, many more in general hospitals, public homes, private homes for the aged, and private nursing homes.

The question which faces us is: To what extent and how should general hospitals *plan* to provide for such patients? Should the general hospital consider itself confined because of precedent to the care of short-term "acute" illnesses? Or has the time come to broaden the function of the general hospital as a place for providing the best medical care available to all sick people *who can best be cared for* by the general hospital, *regardless of how long such care must be given?*

The Commission on Chronic Illness has adopted the point of view that this problem should not be handled merely by exhorting general hospitals and the communities supporting them to be generous in admitting long-term patients; rather, it is one of determining just what general hospitals can do for the chronically ill and how they can best go about doing it. We believe that if the need is shown the remedy will be provided.

A suggested working definition for long-term hospital care is any illness ordinarily requiring 30 days or more of hospital care. The average patient stay in a general hospital is approximately eight days. In Montefiore Hospital, New York City, a hospital primarily for treatment of prolonged illness, the average patient's stay is approximately three months.

Traditionally the general hospital has planned to care for chronic diseases only in the acute phases, for instance, some of the acute phases of heart disease, such as coronary thrombosis, and for the phase of study and adjustment to diet and insulin in cases of diabetes. However, nearly every general hospital of significant size in the country has some patients receiving long-term care. Surveys in a number of scattered communities throughout the country have shown that from 10 to 25 per cent of the total bed capacity of general hospitals has been used for long-term patients. In Chicago a survey showed that nearly 3 per cent of the total general hospital beds were occupied by terminal cancer patients alone.

An estimated one-third of all invalids who cannot be cared for in their own homes are in private nursing homes. Some of these homes have high standards and others are working against financial and practical limitations to provide better care, and some are completely inadequate. Homes for the chronically ill are usually found in large cities, but can provide beds for only a few of the invalids who need such care.

Although homes for the aged traditionally admit only aged people in good health it has been estimated that from one-third to one-half of all persons living in these homes are chronically ill.

In many communities county homes have provided a refuge for the chronically ill who are unable to pay for their care. These institutions have not usually been planned or intended for ill persons and although standards are being improved, most of them need much more medical and nursing service.

All of these various types of facilities still meet only a small and as yet unknown fraction of the need.

In order to determine the general hospital's most useful and practical rôle in the total community problem of caring for the chronically ill it is necessary to find out what percentage of the bed-ridden and wheel chair patients

HOME FOR THE JEWISH AGED, KANSAS CITY, MO.

CLARENCE KIVETT and RALPH E. MYERS

Architects, Kansas City, Mo.

KIVETT and Myers, the architects of the Home for the Jewish Aged in Kansas City, Mo., designed the home for living; they sought to create a home for the Jewish aged by providing complete institutional service in pleasant, informal surroundings, eliminating the institutional atmosphere, because for those who must live their remaining years in a home of this nature, it is essential that an illusion of home life be recreated. Every effort has been made to give to residents that necessary feeling of "being at home" in congenial informality and, at the same time, through the use of contemporary physical design and functional planning, to provide every necessary facility to administer the finest care and social services.

The building is designed to accommodate 75 regular residents and to care for eight residents in the infirmary wing. Living quarters for nurses and the other employes also were provided. Four double rooms make up the infirmary wing. Each two residents of the home share a furnished private room, and a private toilet room.

The exterior construction is brick backed by masonry blocks on a reinforced concrete frame. The floor construction uses concrete pan joist and the stairways are steel pan construction. All of these materials and methods make the building fireproof throughout. Most of the interior walls are 4 inch block plastered on both sides. The windows are steel sash installed in steel subframes.

The flooring used in the building is varied according to the needs of the rooms. The entrance hall floor is terrazzo with a cove base. Linoleum with a cove base is used in the general corridors. The living room, dining room, and chapel are floored in rubber tile. The bedrooms use linoleum with a set-on base. Asphalt tile floor covering is used for staff living rooms in the basement. Special terrazzo is utilized in the kitchen and all bathrooms and toilets are floored in nonslip ceramic tile.

Walnut plywood walls provide an inviting main entrance hall. All of the second and third floor corridor and bedroom walls are covered with a washable fabric. The kitchen walls are glazed tile to the ceiling and baths and toilets employ ceramic tile wainscoting. All other walls in the home are generally plaster.

Generally, the ceiling construction calls for suspended metal lath and plaster, but gypsum acoustical tile graces the first floor entrance hall, the offices and board room, the living room and dining rooms, the chapel, and the second and third floor corridors and lounges, to provide maximum quietness.

A forced circulation hot water system heats the home. The kitchen, laundry, sterilizers, hot water heaters, and other steam equipment are supplied by a high-pressure steam boiler having combination gas and oil burners. Convectors in the bedrooms are placed flush in the walls below the windows and continuous fin radiators at the window walls are provided with perforated stainless metal enclosures.

Mechanical ventilation is provided for the baths and toilets, the kitchen, laundry and windowless basement areas in the new building. The offices and board room are air conditioned and duct work is supplied for future air conditioning in the chapel.

Lighting fixtures are mainly of the re-

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now in their own homes, in nursing homes, homes for the aged, homes for the chronically ill, and county homes should be in hospitals and, conversely, which of the patients now receiving long continued care in hospitals could be adequately cared for in nursing homes or in their own homes.

As in most situations of general community concern, the financial question underlies the entire problem. If every person who was stricken with a disabling chronic illness automatically inherited an income of, let us say, $5000 a year, it is probable that more general hospital beds would be open to such patients than are open now. Medical science has learned that certain chronic illnesses, such as tuberculosis and mental disease, are *best* handled, for relatively long periods, in hospitals. It is quite probable that many more chronic illnesses belong to the same category but few hospital beds are provided for them.

In planning, it is necessary to consider the different amounts and kinds of care patients may need according to their disabilities. Actually no one of the many facilities needed for caring for the chronically ill can be developed separately. Community services and hospital-home care programs that will assist families in caring for patients in their own homes affect the number of beds needed in hospitals and nursing homes.

First, therefore, there is a need for a quantitative appraisal of the problem. Second, there is need for a study of the various types of facilities already in existence to evaluate their effectiveness as methods to be adopted for use in other communities.

In an effort to make the quantitative appraisal of the problem the Commission on Chronic Illness is developing a model community survey and plans to make a study that will measure prevalence of chronic disease and the extent of services needed.

The data which the study is expected to provide are: (a) prevalance of manifest (diagnosed) chronic disease, illness or disability by composition of population; (b) prevalence of nonmanifest or asymptomatic chronic disease; (c) prevalence of illness by diagnosis, degree of disability and duration; (d) prevalence of illness or disability by type of immediate care needed; (e) prevalence of disability by estimated rehabilitative potential, and (f) facilities needed to provide hospital care, home care, rehabilitation, nursing home care and domiciliary care for a given population.

An important by-product of the study, which will be made in an urban and rural area, would be a reliable estimate of the number of hospital beds required per 1000 population to provide long-term hospital care and rehabilitative care for chronic illness.

In response to a number of requests for this service the commission also is developing a model community survey plan for use by communities wishing to survey existing services and facilities for the prevention, control and care of chronic disease. After determining the current local situation through the survey method, a practical blueprint of unmet needs and the best method for meeting these needs—including the most effective rôle for the general hospitals—can be determined through local application of the prevalence indexes developed by the commission.

cessed incandescent type except that fluorescent is used in the offices and continuous strips of fluorescent lighting are used in curtain pockets around the living and dining rooms. The dining room also has suspended indirect domes. Recessed indirect ceiling lights are provided in the bedrooms and all other bedroom lighting will be supplied by movable floor and bed lamps.

Nurses are called by an annunciator call system. A chime signal system and a paging system with loud-speakers on each floor are provided for office calls.

The building's two elevators are self-leveling. The service elevator travels at a speed of 100 feet per minute. The passenger car has a speed of 200 feet per minute. At the present time, no dumbwaiter is necessary, but a shaft has been provided for future installation.

A small portable x-ray unit is planned for the home for emergencies. A complete physical therapy department, rooms for occupational therapy, and recreational facilities will be provided, also, an examining room, doctor's office and nurses' station.

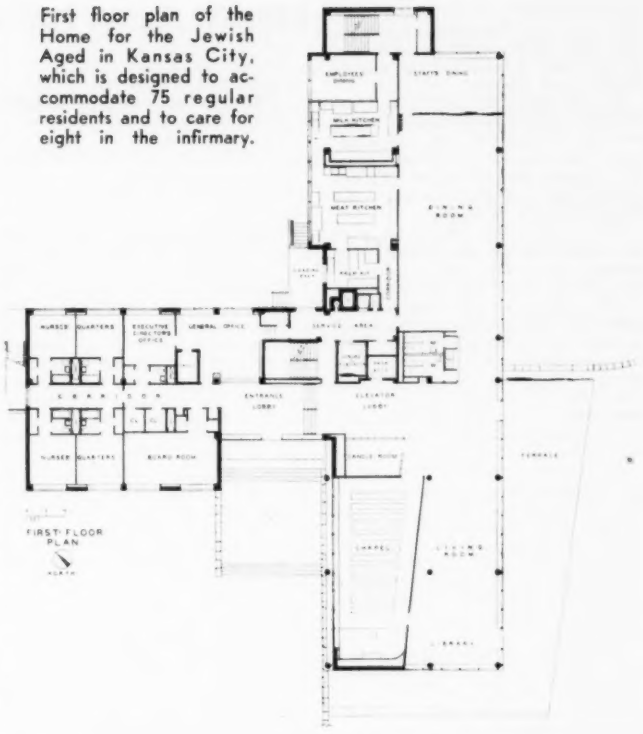
Self-contained units operate kitchen refrigeration equipment. A refrigeration unit has been supplied for the two cold storage rooms in the basement. Self-contained electric water coolers are installed on each floor.

The laundry room is equipped with two washers, an extractor, a tumbler, a two-roll flatwork ironer, and pressing unit.

Equipment in the kitchens will be of the finest, all stainless metal being die formed. The separate meat and milk

(*Continued on Page* 58.)

First floor plan of the Home for the Jewish Aged in Kansas City, which is designed to accommodate 75 regular residents and to care for eight in the infirmary.



Projects similar to the commission's study are the National Health Survey, more recently the study of P. S. Lawrence[1] of the Hagerstown families originally studied in 1923, and the study of Theodore D. Woolsey[2] of 25,000 households comprised in the recent population survey sample of the Census Bureau.

These studies, however, were not planned to include data on extent of disability or need of care. The commission's study, as planned, differs also in that it proposes to include a medical appraisal and examination of a subsample of manifestly chronically ill patients and a screening examination of apparently well persons.

At the present time there are two main approaches to the problem of providing hospital care for the chronically ill. Some groups believe that the general hospital can best accept its responsibility for long-term care by the addition of chronic-care wings or wards. Others look to the construction of more special chronic disease hospitals for the solution. Nearly everybody agrees that nursing homes, homes for the aged, homes for incurables, and county and city homes whose occupants nearly universally need more and better medical care than they are now getting should be helped in raising their standards and have close medical ties with near-by hospitals or medical centers.

Those who do not believe that care of the chronic long-term patient should be in the general hospital point out that such care is inevitably and unavoidably expensive and that chronic patients are usually medically indigent because their resources have already been exhausted during the acute phases of their illness or because of its prolonged duration. The general hospital is not, therefore, financially able to carry this burden nor should it be expected to do so. It is argued that the long-term patient's condition is less dramatic and hence less stimulating than acute illness and may be neglected by the medical staff of a general hospital oriented to the treatment of the acutely ill and that the long-term patient intensifies the shortage of hospital beds more urgently needed for acute patients in the general hospital.

Those who favor the inclusion of long-term care in the general hospital point out: a "Department of Continued Care" in a general hospital is much less expensive to install and maintain than is a special chronic disease hospital where staff and equipment must be duplicated. When the medical staff has been selected with careful consideration for the individual physician's special interests the chronic patient need not be neglected. For diagnosis and therapy the long-term patient needs the same equipment as is now provided for acute patients in general hospitals. Finally, it is argued that the inclusion of long-term patients in the general hospital's program offers an opportunity for education and research in a field which is, and will be, increasingly important to everyone connected with hospital care in the future.

Consideration of the pros and cons of special *versus* general hospital care for the long-term patients must also take geography into consideration. It has been pointed out that in a large city the addition of a chronic wing may

[1]Public Health Reports, Jan. 16, 1948.
[2]Public Health Reports, Feb. 10, 1950.

kitchens have their own gas ranges, refrigerators, urns and dishwashing equipment. The serving pantry on the second floor is equipped with an electric range and refrigerator, and cabinets.

Cost of the home will approximate $726,409. This figure represents a total estimate including land, fees and equipment. The volume of the building is 529,712 cubic feet, making the estimated cost per cubic foot $1.22. The cost per bed for all beds is $5,823.50.

The bedrooms were designed to allow for varied furniture arrangements. The architects spent much time studying several alternate furniture combinations to provide a variety in accordance with the health and preferences of the permanent residents. Bedrooms are furnished with built-in wardrobes, low movable drawer units, writing desks and lounge chairs. Each room has a large window with a center panel of fixed glass flanked by casements. Drapery tracks and venetian blinds will be concealed over the windows.

Open planning with extensive use of glass is intended to give a pleasant atmosphere for comfortable living. The large first floor living room and dining room are closely related, but may be separated by a folding partition. The staff dining room is separated from the main dining area with a folding partition so that for special events all three spaces can be combined into one large room.

The chapel is designed to seat 100 persons. The continuous casements are glazed with obscure glass with provisions for installing panels of stained glass on the inside of the windows.

HEBREW HOME FOR CHRONICS, NEW YORK

LOUIS ALLEN ABRAMSON and ISADORE ROSENFIELD

Associated Architects, New York City

AT ANY price per cubic foot of construction, it is possible to plan on a luxurious standard, providing each patient with a private room and bath, or to plan modestly in nursing units of reasonably graded accommodations from large wards to a few single rooms for the very sick. The luxurious type requires an enormous amount of building volume compared with the modest type. The cost difference between the luxurious and the modest types can be considerably more than 100 per cent. The advocates of the private room hospital point to the inhumanity of the large ward, and they can hardly be blamed for that. But in such cases they usually have in mind the old-fashioned, one-room barracks type of ward. From this they go to the other extreme, the one-room-one-patient hospital.

Laying utopia aside for the moment, there is a great deal to be said for the nursing unit with the graded type of accommodations, where the gregarious can be housed in larger units, the less gregarious and the more sensitive in smaller units, and the very sick or the very sensitive in single separation rooms. After all, there are people who would rather endure bedpan technic (behind curtains) in a congregate ward than to suffer isolation and loneliness in a private room.

The Hebrew Home and Hospital for Chronic Invalids in New York is an example of graded accommodations, but on a modest level. There are 24 bed, six-bed, three-bed and two-bed wards, but no single rooms. However, all the beds are cubicled and curtained. The nursing units, of which there are six, are relatively small, averaging 32 beds, and each nursing unit has a solarium of ample proportions.

While the bed accommodations are modest, the services and amenities are much more highly developed. This, again, follows the pattern of reasoning that if you cannot have both, it is much more important to have decent services and amenities than it is to have private bedroom accommodations. It must be remembered that these patients spend here not days and weeks, but months and years. They must find themselves at home here as well as in a hospital.

One of the interesting features is the synagogue which is meant to serve the community primarily, but which will be avail-

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make the hospital plant too large to be administratively feasible. Here, of course, the special chronic disease hospital might be most practical and, in addition, the larger volume of need and central location would attract the specialists and staff needed. Special chronic disease hospitals located near and closely related to medical centers would seem to be a practical solution in that kind of area.

In an effort to come to grips with the problem there have been many different plans for providing long-term care by hospitals throughout the country.

Approaching the problem by providing care for the chronically ill in the general hospital, the Menorah Hospital in Kansas City plans to open a floor of 50 beds for the care of the chronically ill early in 1951. The medical staff of the hospital will extend the service assignments in its specialties to include care of chronically ill patients. Both graduate nurses and nurse's aides will be assigned on this floor with a higher percentage of aides than on the acute floors.

Springfield Hospital in Springfield, Mass., a general hospital, has been caring for the chronically ill for 14 years. The solution to the problem of possible neglect of chronic patients because of greater staff interest in acute cases has been worked out in Springfield by placing an intern in charge of the chronic ward for the period of his stay. He visits patients and calls into consultation the head of any service whose advice is needed. An annual reexamination for evaluation of the patients' needs and a complete ward round made monthly by the hospital superintendent, intern, supervising nurse and social worker have made possible a successful program of caring for the chronically ill in a chronic unit of a general hospital.

As of March 31, 1950, the Public Health Service had approved 19 projects for chronic disease units in general hospitals.

In Chicago, Michael Reese and Mount Sinai, both general hospitals, have close affiliations with two homes for the aged and one convalescent home in three new buildings recently constructed by the Jewish Federation of Chicago.

These include a modern 50 bed facility for the care of the chronically ill next door to the Home for Aged Jews; a three-story addition to the Orthodox Jewish Home for the Aged, and the new Rest Haven Convalescent Home providing 40 beds.

Special chronic disease hospitals have long been established in some larger communities and have pioneered in the development of effective methods of dealing with the problem.

St. Barnabas Hospital for Chronic Diseases in New York City, established in 1866, fulfills the three-fold need of chronic patients for acute care, subacute care and domiciliary care with a program that offers hospital care with intensive nursing and medical service for the acute stages, skilled nursing care with regular medical supervision under the same roof, and when continued care is no longer needed residence for the aged in Braker Memorial Home operated by the hospital. Braker residents, who become ill, can be immediately hospitalized in St. Barnabas and have easy access to its clinics and special departments for ambulatory care.

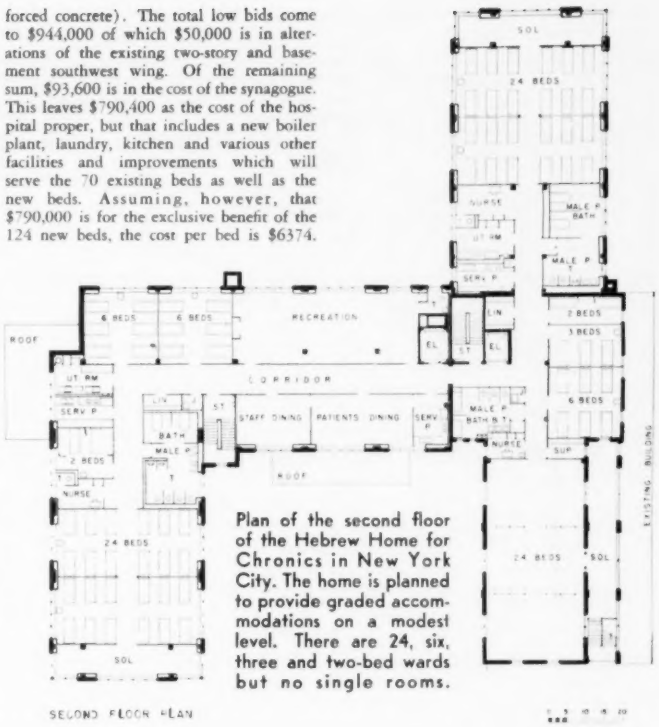
able to the patients. The synagogue is, therefore, an important link between the patient and the community. Meeting with the community at prayer restores the patient's sense of unity with society and makes him feel that he is not an outcast and forgotten. For daily small group prayers there are available, in addition, the ladies' auxiliary room adjoining the synagogue and the recreation room on the third floor. All three of these spaces are available for all sorts and sizes of social functions with and without community participation.

While the dining room on the second floor will serve the obvious purpose for ambulant patients who will comprise about 50 per cent of the patients, such patients can find further diversion and mental therapy in the occupational therapy room on the third floor. This room, incidentally, leads to a roof terrace which faces southeast and commands an extensive view.

The third floor also has the major diagnostic and therapeutic facilities. Here there are a minor surgery room (for major surgery the patients will be sent to an affiliated general hospital), a medical consultation room, a laboratory and pharmacy, basal metabolism and electrocardiograph room, a radiographic suite, dental and podiatry facilities, and, finally, an ample physical therapy department. To supply the house with sterile goods, the third floor also has a central sterile supply room with the necessary autoclaves.

CUBAGE AND COST

The existing wing, as well as the new work, is of fireproof construction (reinforced concrete). The total low bids come to $944,000 of which $50,000 is in alterations of the existing two-story and basement southwest wing. Of the remaining sum, $93,600 is in the cost of the synagogue. This leaves $790,400 as the cost of the hospital proper, but that includes a new boiler plant, laundry, kitchen and various other facilities and improvements which will serve the 70 existing beds as well as the new beds. Assuming, however, that $790,000 is for the exclusive benefit of the 124 new beds, the cost per bed is $6374.



Plan of the second floor of the Hebrew Home for Chronics in New York City. The home is planned to provide graded accommodations on a modest level. There are 24, six, three and two-bed wards but no single rooms.

SECOND FLOOR PLAN

Combining domiciliary and hospital care under one roof, Springfield, Mass., now plans a 600 bed institution, with 300 beds for chronic hospital care with all clinical facilities and a 300 bed custodial section. The new half hospital-half domiciliary structure will be joined with a comparatively new existing building which will be devoted to the care of communicable diseases, tuberculosis and psychiatry.

Cottages for married couples and dormitories for single patients are included in the plans for a new hospital-community in New Britain, Conn.: a 200 bed hospital for the care of the acute phases of long-term illness; 100 bed section with 24 hour nursing services for subacute patients, and 350 bed domiciliary facilities in cottages and dormitories.

Rehabilitation is the chief emphasis at the new Maimonides Health Center in San Francisco. "A hospital for the chronic sick," its proximity to Mount Zion Hospital enables use of the same power plant, pharmacy and laundry, avoiding duplication of those facilities.

An increasing awareness of the need for more hospital beds for the chronically ill has stimulated municipal planning and building in many parts of the country.

New York City's recent construction program built 8558 beds, to bring the total to 10,500 municipal beds for chronic care. This program provides not only for the long-term patient, but also for the aged and infirm who need convalescent and domiciliary care.

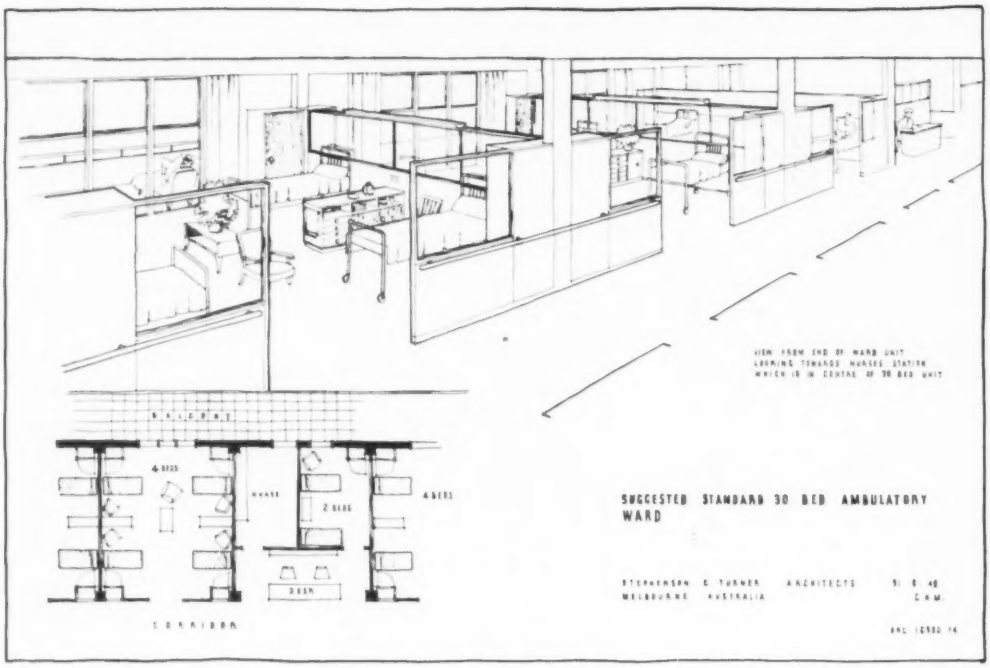
San Francisco's Laguna Honda Home and Hospital similarly recognizes the relationships between the chronically ill and the need not only for extensive medical care, but for subacute care and sheltered residences for the aged.

In Chicago, while Oak Forest Home and Infirmary provides facilities for the chronically ill, the city plans to build a geriatrics institute and, cooperating with the University of Illinois Medical School, is developing a hospital program designed especially for the care of the chronic patient.

Cleveland is in the process of drawing plans for a 480 bed chronic disease hospital, in cooperation with Benjamin Rose Institute. It will be affiliated with Western Reserve School of Medicine.

Home care programs as an organized extension of hospital care are another approach to the problem of providing the best and at the same time the most economical care for the long-term patient.

Montefiore Hospital in New York City, a special chronic disease hospital, has pioneered in the development of a home care program designed for patients who, with such services, are considered no longer to need hospitalization. If the physical condition of the patient and his home environment indicate that home care might be practical he is transferred to his own home. Montefiore Hospital provides medical services, including specialist consultation any hour of the day or night; social service from the regular staff; nursing care and instruction through the Visiting Nurse Service of New York; housekeeping service to aid the housewife; transportation to and from the hospital for special treatment and examinations; occupation and physical therapy in the home, and all necessary medication and appliances.



The cost of the home care program is $3 per day compared with the $12 to $15 daily cost for care in the hospital.

Home care, however, is conceived not as a way of saving money, but as a really better way of caring for this kind of patient. He has the comfort and familiar surroundings of his own home and more personalized medical service from the physician who visits him in his own home and sees him in his social and psychological environment.

Five hospitals participate in the more recently developed home care program of the New York City Department of Hospitals: four general hospitals and one special chronic disease hospital. Under this personalized medical visiting service the patient is cared for in his home by the same members of the hospital medical staff who had frequent contact with him while he was in the hospital. To make this possible the resident medical staffs have been increased.

The home care service is provided to any indigent patient whose needs can be met by bringing hospital service into his home.

In Chicago, doctors and social workers at Michael Reese and Mount Sinai are visiting some patients in their homes. Under this plan the patient is first treated in the hospital during his acute illness, transferred to one of the "homes" for the care of the chronically ill for long-term care, and is eventually released to his own home when he no longer needs such intensive treatment.

Prolonged *care* of the chronically ill is only one facet of the three-fold approach to the problem facing all community facilities, including hospitals. The others are prevention and rehabilitation.

Prevention and, secondarily, detection and control are now generally recognized as basic approaches to a long-range program; rehabilitation may give the patient an increased self-sufficiency, thus lifting at least a part of the burden of his care from the shoulders of others. The extent to which programs designed to prevent and rehabilitate are successful will also affect the future need for different types of services, including hospital facilities and care.

Participation in secondary prevention and rehabilitation, as well as in inpatient and outpatient care, may well be useful and logical activities of the general hospital.

Multiple screening, a device for detecting nonmanifest chronic disease so that its progress can be prevented or controlled, is also being experimented with by some general hospitals.

A *multiple screening* program has been initiated at the New England Center Hospital in Boston in cooperation with the Massachusetts Medical Society, Massachusetts Department of Health, and the Public Health Service. The clinic provides free screening, and a trial run revealed that nearly half of the first 753 apparently well people examined were referred to their physicians for a total of 449 previously unknown or untreated defects.

There have been some pioneer efforts to establish rehabilitation centers in general hospitals. Two of the most outstanding centers of this kind are those at the New York University—Bellevue Hospital Center and at Philadelphia General.

In 1949 the Grace-New Haven Community Hospital, a general hospital, received a grant from the Connecticut

Commission for the Chronically Ill, Aged and Infirm to set up a "rehabilitation service." Studies by the Connecticut commission had indicated that state patients suffering from chronic illness were "lost" in general hospitals and convalescent homes because there was no special facility to rehabilitate them. At the Grace-New Haven Community Hospital a floor was set aside and equipped, containing a 31 bed rehabilitation unit. Twenty beds were reserved for patients referred by the state and 11 for other patients.

REMODELED FOR NEW USE

Many changes were required to adapt the former acute ward to its new use. The first major change was to increase the bathroom facilities since both sexes were to be kept on this division and most of the patients would be ambulatory. Two toilets and a shower were provided for men and the same for women. Hand rails had to be added in toilet rooms and showers to assist this new kind of patient. The solarium was redecorated and new furniture was manufactured. The chairs had to be firm as most of the patients could not sit in an "easy chair." The tables had to be so constructed that wheel chairs would fit under them. It was necessary to obtain a supply of wheel chairs with all types of adjustments so that each patient could be assigned a wheel chair that met his individual needs.

Even though the hospital was a university affiliated institution of almost 500 beds, there was no formal occupational therapy department and this was an absolute essential for the development of a rehabilitation service. So the waiting room for the floor was converted into an occupational therapy room and a therapist was obtained. This department opened in October 1949 and is now the most popular room on the floor. The occupational therapist is definitely part of the medical team and directs the therapy according to the patient's needs.

The physical therapy department needed expansion in both equipment and personnel. Therapists were added to the staff and new equipment was purchased. The chief physical therapist is also part of the team, and part of the weekly consultant rounds are held in the physical therapy department.

The social service assignments were changed so that one worker would have sole responsibility for the rehabilitation patients.

The volunteer service obtained a television set for the solarium and also arranged for regular movie shows in the solarium.

The present plan of medical services is as follows:

1. Daily rounds of full-time medical director with house staff.

2. Consultations in all specialties when requested. Orthopedic and psychiatric consultations are the most frequent.

3. Weekly rounds with consultant in physical medicine and rehabilitation from Rocky Hill. The social service worker, physical therapist, and occupational therapist all participate in these rounds. When possible, the orthopedic consultant and psychiatrist also attend these rounds.

The two year old pilot study in rehabilitation at Rocky Hill Veterans' Home and Hospital in Connecticut is considered a successful "reemphasis of the totality of the human mind, body and spirit." It is carried out in a 700 bed barracks for housing of any veteran, and a 420 bed hospital. Chronic patients are admitted upon referral from a physician and state and local departments, and veterans are admitted without referral, although all go through the hospital for screening before admission to the barracks.

These points of approach to the problem through both general and special hospitals, affiliations with homes for the aged, hospital-home care, multiple screening clinics, and organized rehabilitation services give some indication of the pattern that is now developing in facilities for the chronically ill. They are only isolated examples, however, and no one really knows at present the complete current national picture on the extent to which general hospitals now offer planned care of the chronically ill and the number of them which have organized rehabilitation units and home care programs. The Commission on Chronic Illness is planning to send a questionnaire to all general hospitals in the United States in an effort to collect this information which is fundamental to planning on the national level.

The rôle of the general hospital in care for the long-term patient is, of course, only one aspect of the total problem with which the Commission on Chronic Illness is concerned. In addition to the studies mentioned earlier, the commission's technical staff in Chicago is gathering information about chronic disease planning activities now underway in various parts of the country. Questionnaires have been prepared and sent to state health departments, state medical societies, and 387 local community chests and councils. The commission will also make a study of the programs of state and local welfare departments and of the national voluntary health organizations.

Recognizing the need for study of the many problems—medical, social, economic—which are both the causes and effects of chronic illness, four national organizations, each with a stake in the problem, joined to form the Commission on Chronic Illness in May 1949, *i.e.* the American Hospital Association, American Medical Association, American Public Health Association, and the American Public Welfare Association.

IS AN INDEPENDENT AGENCY

The commission is now an independent national agency. Its 33 members are prominent in the fields of medicine, business, industry, labor, education, government, agriculture, hospitals, religion, public health and public welfare. It is financed by the American Cancer Society, American Heart Association, American Medical Association, National Foundation for Infantile Paralysis, National Society for Crippled Children and Adults, Inc., National Tuberculosis Association, and the New York Foundation. The Public Health Service has contributed some staff services and the American Medical Association, in addition to a financial contribution, has provided office space and the use of its office facilities.

The research approach of the Commission on Chronic Illness will attack the problem on the national level. However, an equally important job of the commission is to stimulate each state and community to study its own problem—and to assist it in doing the job.

In addition to collection and dissemination of information on chronic illness programs and assisting and advising national, state and local agencies, the commission will stimulate or perform needed research, develop standards and criteria for programs, carry out an educational program for the profession and the public and finally prepare program plans and recommendations for communities, states and the nation.

a primer of

PUBLIC RELATIONS

for the hospital field

THE other day, a friend of mine, a learned and distinguished professor with a nationwide reputation in his field, was a patient at the Emory University Hospital.

Professor X was a genuinely sick man, and he knew it. He knew it so well that his docile acceptance of the most minor dictum of his doctors or nurses astonished his associates, who knew of his independence and lack of patience with any kind of regimen.

As he began to mend, however, and the awful prospect of the abyss began to recede, his beloved cantankerousness reasserted itself. It soon developed that the principal target of his ire was to be the hospital food. After a day or so, his lamentations about the quality of his diet assumed heroic proportions.

As soon as the first whisper of rubber-tired carts murmured in the hall at mealtime, he would assault the ears of the nearest listener with complaints about the "sameness," the "tastelessness," the "lack of imagination," in Emory food. He ate it, he maintained, only in order to cement the seemingly tenuous bond between body and soul.

MRS. PROFESSOR STEPS IN

At last one day even Mrs. Professor X wearied of his ceaseless tirades. At the family grocery store that morning, she procured the finest filet mignon which money could buy. Taking it to the hospital that afternoon, she cooked it with her own hands in the diet kitchen, searing it on both sides quickly and then removing it to the plate dead rare—the inside still cool. Just as HE 'iked it!

By special arrangement, this plate went directly to the floor and straight to patient X. No mention was made of there being anything special about his steak; the professor was simply served his dinner, without comment.

You know how the story ends. That evening, Mrs. Professor, in the tone of one who makes conversation, asked friend husband what he had had for dinner.

"Steak," he growled.

"How was it?"

"Terrible! Just like everything else —tasteless and overcooked!"

There isn't much you or I can do about the Professor X's of this world. Because of circumstances beyond our control, they have made up their minds they aren't going to like us. In their right minds again, after the enforced hospitalization is over, they will probably come around, anyway.

But hospitals—many of them—*have* done something about the age-old problem of patients who complain about the food. One answer, of course, is better food. Another is selective menu service—giving the patient a choice, within bounds as broad as possible, of what he will eat. Without changing food preparation methods an iota, scores of hospitals have reduced food-gripers to unbelievably low percentages with this simple gimmick.

That's the practice of public relations. Identifying a problem. Isolating it. Finding an answer to it. And then putting the solution into effect.

But that's not all. Back of the action lies something more important—an attitude of mind, a way of life. You've got to *care* about that patient; not just care what he thinks about you and your hospital, but care about him as an individual. You must be committed to a way of life whose whole emphasis is upon service.

I once heard of a young man so convinced of his own sterling qualities of mind and spirit that every time his birthday came around, he sent his mother a telegram of congratulation.

BRADFORD D. ANSLEY
Director of Public Information
Emory University, Atlanta, Ga.

Too many executives, in every type of management, think of public relations as a matter of the constant preparation of telegrams of congratulation to the public. Oh, if it were only that easy!

Actually, if I were to set out to formulate a definition of public relations, I think I would tee off from a remark made recently by Paul Hoffman of the E.C.A. Speaking of the world-wide ideological conflict in which the U.S. is engaged, Hoffman said, "You can't export American know-how. You can only create the conditions under which other people will want to import it."

CAN ONLY CREATE ATMOSPHERE

There is a direct parallel with hospital public relations. You can't jam the hospital story down the throats of readers and listeners. You can only create an atmosphere, through your public relations program, in which people will react favorably to your institution and will be open-minded toward your message.

On the basis of this sort of thinking, let me belabor my point just once more. Public relations is not simply a *responsibility* of management; it is a *duty*, or better still, a *condition* of management. Like the Boston lady who was asked by an outlander where, in Heaven's name, she got her hats, and replied stiffly, "My dear, we *have* our hats," your hospital *has* its public relations. They may be good, bad or only indifferent, but they are there. And they are the concern of top management because, as the navy puts it, "public relations is a function of command." The hospital administrator can no more escape or delegate responsibility for the public relations of his house than he can delegate the function of breathing. He can find specialists to help him, yes. But the final duty lies with him, because public relations refers inevitably and inescapably

to policy, and he is the top policy-making officer.

The everyday practice of public relations, then, has to do, first, with policy and, second, with the engineering of acceptance for that policy. As one writer has put it, it's a matter of "doing good and then telling folks about it!"

But the word "engineering" is important. Public relations is not fuzzy-minded do-gooding. It isn't trying to please everybody, because that's impossible. It doesn't mean compromising the integrity of your operation in the vain hope of quieting the last whisper of criticism. It means, rather, a constant concern with developing attitudes and opinions, with conditioning reactions, with presenting facts.

A good start on the development of an intelligent and effective program of public relations ought to start with the asking of three questions:

1. What do my publics think of me *now?*
2. What do I want them to believe about me?
3. What technic will I use to convert 1 into 2 and to extend greatly the number of those who appreciate me?

THE ANSWERS CHANGE

The answer to none of these questions is an unchanging matter. They must be asked not only in the beginning, but constantly and everlastingly, which is another way of saying that you must have an intelligent awareness of the climate of public opinion in which your hospital exists. That, in turn, may in some cases mean painstaking research to ferret out the answers to 1, and straight-forward and clearly-defined purposes in the case of 2. Actually, the answers to 3 are by far the easiest to come by.

The first rule in getting at the answers upon which to build a program is "Know Thyself." There are too many of us in public service agencies of all kinds who often think more of our own convenience than of the public welfare. How recently have you taken the trouble to run down a recurring source of complaints—say, in the slowness of your admissions procedure—and asked yourself seriously whether you were carrying on that particular operation in that particular way for the benefit of your patients, or just for your own convenience? You must be absolutely merciless in this self-analysis, and then you must

be willing to make changes when you have isolated policies which are sources of trouble.

The second rule is "Know your constituency." And that's tough to do. The best way, of course, is by means of scientific opinion surveys. But most of us haven't the funds with which to finance such projects. There are other ways. I would list three main ones: Keep your mind open. Keep your door open. And keep your policies open to discussion, suggestion, criticism.

Under these conditions, it will be possible for you to keep in touch with your publics: your employes, your house and nursing staff, your professional staff, your governing board, and the many others. Cultivate the ability to put yourself in the place of the patient or the orderly. Try to understand his need for understanding, for comfort, for recognition, for reward.

Make friends outside your hospital. It's easy to "live over the shop," so that you actually never leave the house, but only associate with friends who think as you do and talk as you do and react as you do. Get out of the hospital atmosphere as often as you can—and then, listen! You can become a remarkably sensitive sounding board for public opinion.

In short, you need to know where you're going, how you're going to get there, and what the public opinion obstacles are that will beset your path. Those obstacles, let me say hurriedly, are not necessarily the same in any two hospitals, even in the same city. There are, however, some similarities, some focal points, on which all of us must continue to work. Some months ago, *U.S. News and World Report* compiled some figures on medical care which are disturbing to me personally. This publication, whose figures, of course, I cannot vouch for, says that Americans spend some $7 billion a year for hospitals, doctors and medicine. Yet, they say, only one family in five has adequate medical care. I don't know by what standard they measure adequate medical care, but if their figures are correct, they point up the dilemma of the average citizen who doesn't want government meddling in medical affairs, but who wants his family taken care of. A lot of people know something needs to be done and they are looking to you for leadership. Here lies your greatest opportunity!

We have implied that you are working in the dark, in your P.R. efforts, unless you know what people think about you. In just the same way, you are working fruitlessly unless your public relations activities are *aimed*. The effect of your program must be that of a rifle, whose sights are drawn on a specific target and whose impact goes unerringly to that target. The shotgun technic of talking so much that someone is bound to hear you is simply so much wasted effort. You have not one "public" but many, and you must analyze each and design a program rifle-aimed at each.

AT LEAST 10 PUBLICS

Let us list a few of those publics. A beginning might look like this:

1. Patients
2. Doctors, staff and nonstaff
3. Nurses, your nursing staff and the nursing profession
4. Patients' families
5. Visitors
6. Other hospitals
7. People you buy from
8. The leaders of your local community
9. Governmental agencies, local state and federal
10. Health and accrediting agencies

Remember—*no single public relations effort is going to reach all of these publics.* The chances are no one effort will reach more than two or three of them, at best. To be really effective, your program must provide tailor-made, rifle-aimed contacts with each.

Some of these groups are obviously more important than others. From a layman's standpoint, I'd like to discuss just two and what it seems to me you might do to set up a program for them.

Public relations, like charity, begins at home. One of your most important publics, then, is certainly made up of your patients.

If there is one characteristic of patients which can be isolated, like a virus, and declared indigenous to the breed, it seems to me to be that they are so easily and deeply affected by *little things.*

I'll quote a story in point. In the days when air conditioning was some-

thing new and little understood, a large department store in New York contracted with a certain engineering firm for the installation of a complete air conditioning system. Tackling the job with the realization that success might mean many more orders, the firm assigned to the store its most talented young engineer. After weeks of painstaking effort and the exercise of the greatest care, the young foreman at last announced to the store management that the system was complete, that it could be turned on for operation when the store opened the next morning, and that, from then on, windows and doors were to be kept closed in the interests of efficiency.

The next day, after only a few hours of operation, the store management put in a desperate call to the installation firm, demanding that something be done. The system was not working. With windows down and doors closed, several salesgirls had already fainted and been carried off to purer air.

Rushing to the store with his thermometer and gauges, the young engineer tested every part of the store for temperature and humidity. The tests came out—perfect. And yet employes all over the store were complaining of the closeness: "No air," they groaned.

THE RIBBONS DID THE TRICK

For a moment, the engineer was baffled. Then, with one of those strokes of public relations genius which we all envy, he had an idea. Scooping up a roll of pink ribbon from the notions counter, he took a pair of scissors and a stepladder. To every grill from which cool air was being pumped into the store, he attached a short length of ribbon, which immediately began fluttering merrily in the breeze. Then, after fiddling briefly with the machinery controls, he announced to the management that the air conditioning system was now functioning properly and should give no more trouble.

Relieved, the salesgirls went back to their counters, looking up happily at the pink ribbons snapping their guarantee that fresh, cool air was indeed flowing into the store.

There were no more complaints about the cooling system.

Isn't it possible that we can look around our hospitals and find some inexpensive ribbons to tie to many of the things we do which will make them more understandable and more palatable to our publics?

I have heard it said that we could kill a patient with a big mistake and he would go to his death blessing our name. But he'll damn us forever for serving him cold coffee in the morning!

This means two things: First, do nothing to give your patients a bad impression about you; and, second, do everything you possibly can to give them good impressions. This is probably never more important than at the time of admission. This is a difficult time for the expectant mother, the preoperative hernia case, or just the "general check up" patient. He is worried, jumpy. His reactions are exaggerated. Your initial impact upon him must be such as to relax him, to instill in him confidence that you know what you are doing and that you have his best interests at heart, in short, that he is in good hands.

MANY PEOPLE ARE AFFECTED

The American Hospital Association quotes some statistics which give an insight into just how important your patient P.R. program can be, over and beyond the impact upon the individual himself. Each patient brings with him the interest of at least five other persons who are relatives or friends, based upon the national average of four persons per family and assuming that he must know at least two other persons rather well. In the case of a 75 bed hospital, then, the 2700 patients admitted each year actually constitute a contact for your hospital with 13,500 individuals! If you have a busy outpatient department, the figure will be even higher. That's a lot of people of whom to make enemies or friends; a lot of potential good-will ambassadors, if properly handled.

There are certain obvious ways in which you can attempt to sell your patients on the social value of your hospital and its worth as an institution. You can educate them in its historical background, its purposes and objectives. Who "owns" your hospital? How does it operate? What are its services to the community? Where does the money come from to operate it? How do you spend that income? Perhaps most important right now, what is the story on the high cost of hospital care?

These facts can be got across in a number of ways: by means of booklets, leaflets, newsletters, and so forth. But the word of mouth method is always best. And, here again, your admitting office is of first importance. Because it is here that the patient first learns many things about the way you run your hospital and forms his first opinions about whether he likes it or not. The way he is treated by your admission clerk can swing the pendulum in his mind from good to bad or back again. That means a person of high caliber in the job. It means someone with an instinctive liking for people, and an ability to put them at their ease. It means someone with a calm manner, with an air of efficiency but without officiousness. The task can, of course, be lightened by preadmission indoctrination and by constant indoctrination of your staff physicians, who can prepare the patient for what to expect. But the burden on your admitting office is still there, and it behooves you to see that it is being borne properly!

Important, too, both at admission time and afterward, are the relatives and friends who so often swarm into your lobby, "helpin' Aunt Suzy to the hospital." You should develop a system for handling them during the admission and immediate postadmission period so that they do not wander around for hours wondering whether Aunt Suzy is alive or dead. Some specific individual should have the responsibility of notifying them whether they can see Suzy and, if not, whether they should go home, wait or come back later. Above all, give both the patient and the family the feeling that you are competent but human; that this strange and terrifying place, so often a place of fear and pain, is not just a huge machine about to devour them, but a warm and friendly haven of release from agony.

EXPLAIN THE REASONS

When the patient is safely ensconced in his bed and his family and friends are satisfied of your competence to care for him and your interest in his welfare, you still aren't through. Efficient bed care isn't enough, either. Keep remembering that these procedures which are so simple and obvious to you may be strange, mysterious—even nonsensical—to him. Try to make plain to him the reasons behind everything you do. If you must carry out certain examination procedures, explain to him that these are being done on the order of his physician, in his best interest. It isn't necessary to pamper him, but it is always advisable to tell him everything about your actions consistent with his own welfare.

One more thought. The departure period is also of vital importance. He is glad to be going, and in these crowded days, you are glad to see him go. But try to leave a pleasant taste in his mouth. And what about your follow-up? Do you have any? Don't let his canceled check or his final bill be the last memory he has of you. A form letter, printed or multigraphed, might be just the note which would make him an enthusiastic booster for your hospital, rather than a man remembering a bill which wiped out the savings of 10 years.

IT STARTS WITH THE STAFF

The other public I want to discuss briefly is the one composed of your staff and employes. Our discussion of patient relations has already raised in your mind the question, "Who is going to do all these jobs?" Certainly, the hospital administrator can't be a personal salesman with every patient, every relative, every visitor. The fact is, your hospital's public relations program will be carried on largely by nonadministrative personnel, untrained for the job. Your public relations are likely to be created, for better or for worse, by your visiting and house staff, your nurses, maids, orderlies, janitors, clerks, bookkeepers, and workmen—by everybody, in short, who has any contact with the public. And that's everybody!

Since, then, the actual day-to-day operation of your public relations program is largely out of your hands, you must train, sell, educate those who do carry it on. A short-shot selling job is not enough either. Your effort to make public relations ambassadors out of the people who work in your house must be a double-barreled one—first, indoctrination and, second, continuing information.

Only when every employe and staff member feels like a member of a team; only when his sense of participation has been aroused and his loyalty quickened by an understanding of the importance of his rôle, no matter how small, in the life of the hospital; only when these things have been accomplished, will he be a good-will getter for you.

One of the best ways to arouse this sort of loyalty and enthusiasm is by keeping your people informed. Secrecy is the abiding sin of too many hospitals, as it has been of too many universities and too many business organizations. There is precious little loyalty in a machine-cog. If you make your staff members feel that they are simply cogs in the hospital machine, then don't expect much loyalty or much selling enthusiasm out of them. But if you keep them informed about your plans and accomplishments, if you let them in on your own deep-felt dreams of what the hospital can accomplish, there is literally no limit to the gold mine of good public and private relations which you can tap.

The tools? The same ones we have mentioned before: the pamphlet, the newsletter, the staff conference, and the open office door.

Now, a final word about press and publicity relations. They are important, although I hope we have seen that they are only *part* of a well rounded program of public relations.

The newsman has a traditional concept about hospitals—that they are places where the three bad "R's" of public relations abound: resistance, reticence and red tape.

Remember two things: (1) You must live with the press. Try to make it a happy marriage. (2) You can't keep a good story down, and, by good, I mean newsworthy—whether it happens to be your idea of good publicity or not. The press has an uncanny way of finding out about news, and there is no force under the shining sun more implacable than a good reporter on the trail of a good story.

Cooperation all along the way will mean help from the newspapers when you need it, and understanding when you occasionally do have to say, "no." If the story is bad medicine for your hospital, just remember that it's a lot better to get your version of it before the newspaper people, not somebody else's garbled one.

All this adds up to more than just an attitude of cooperation. It means a system of press relations, the basic foundations of which are that (1) someone must be available at all times, authorized to talk to reporters; and (2) there must be a publicity policy which is clearly understood by everyone involved. Reporters can't wait until "tomorrow morning, when he'll be in," with a deadline staring them in the face. And they don't like the game played by different rules every time they come on the field.

I cannot, however, get very excited about press codes. Codes, once they have been prepared, are a little like the old music teacher who, trying to teach a youngster something about voice, complained that he "played on the white keys and played on the black keys," but the pupil insisted on singing in the cracks! The more detailed your code, the more confusion is likely to develop over whether a particular case fits the white or the black keys. Too many are likely to fall into the cracks.

A general statement of policy, administered by informed and capable personnel, strikes me as being much more workable. Under any circumstances, the basic necessity is an understanding by the press of your rôle in the medical care picture; the fact that you are largely an agent for the doctor; that hospital charges are often out of your hands because of procedures ordered by the physician; that your function is that of service. How you will go about getting that across to the press is an individual problem with you. Some hospitals have done it with annual press dinners. Others have public relations men whose job it is to establish mutually friendly contacts. Still others rely upon the skill of the chief administrator in dealing with each instance as it arises. Any of them will work if it is based upon a desire to cooperate and an understanding of the issues involved.

MUST JUSTIFY EXISTENCE

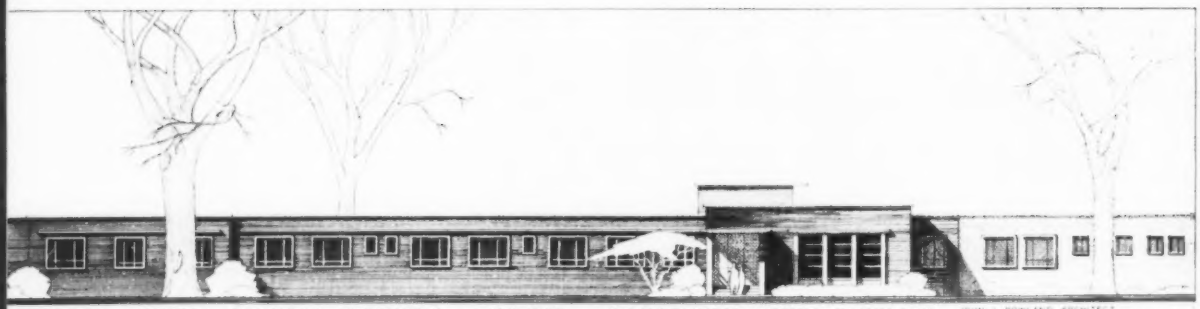
In the competitive society in which we live, every organization and institution, every agency of service, is called upon every hour of the day, whether we like it or not, to justify its existence in terms of the public interest. The hospital, no less than the enormous corporate enterprises which bulwark our economic system, must seek deliberately and constantly to engineer a climate of understanding cooperation in the public, if it is to survive and develop into greater usefulness. This technic of "air conditioning" the climate of public opinion we call public relations.

In thinking about your public relations, steer clear of the two pitfalls which are so inviting and so dangerous:

Don't shrug it off as a high-powered term for publicity and press agentry and, therefore, beneath your dignity.

And don't, on the other hand, convince yourself that there's something mysterious and highly technical about it which can only be understood by the professional.

Your public relations are with you every moment of every day. It's up to you whether they are good or bad.



WARREN COUNTY GENERAL HOSPITAL ·· 35 BED ·· WARRENTON, NORTH CAROLINA

OBJECTIVE ACCOMPLISHED—

To Keep Costs to a Minimum

Project Cost: $337,277
(including group I and II equipment)
Cost per cubic foot, $1.56
Cost per bed, $9640

PLOT PLAN

THE 35 bed Warren County General Hospital at Warrenton, N.C., was planned by John J. Rowland, architect, and James M. Simpson, associate, to meet the standard established by the North Carolina Medical Care Commission, which insisted that costs of Public Law 725 hospitals be kept to a minimum so that federal and state money could be more widely distributed and used most effectively for the purposes for which the appropriation was made.

That this objective has been successfully accomplished at Warrenton is apparent from the costs reported by the architects on this project—$7980 per bed, or $1.29 per cubic foot for construction. With equipment and fees included (but without land costs), the completed project cost $9640 per bed, or $1.56 per cubic foot, the architects reported.

The town of Warrenton is an old colonial community, but the architects did not feel that the colonial style was appropriate for a modern hospital. "We were not willing to do a colonial hospital as we thought it would not serve the needs of the locality," Mr. Rowland said. "However, we used brick and stone so that the hospital would be related to other elements of the community."

Exterior walls are of face brick and block. The floor is concrete covered with asphalt tile throughout most areas of the hospital. In toilet areas the floor is ceramic tile and in the kitchen, food service and adjacent storage areas it is quarry tile.

The roof is constructed of steel joists and concrete slab covered with a 20 year guaranteed built-up surface.

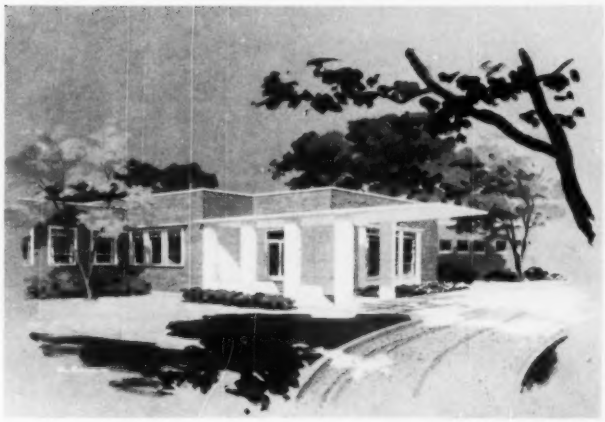
The hospital plan is a foreshortened "U" with a diagonal addition, like the tail of a "Q," which houses the kitchen, food service, dining and storage facilities.

The 35 beds are mostly in single and two-bed units. A single nursing station serves the entire patients' area which is set apart from the principal entrance, lobby and public waiting room space by the interposition of administrative and business offices, the staff room and record library.

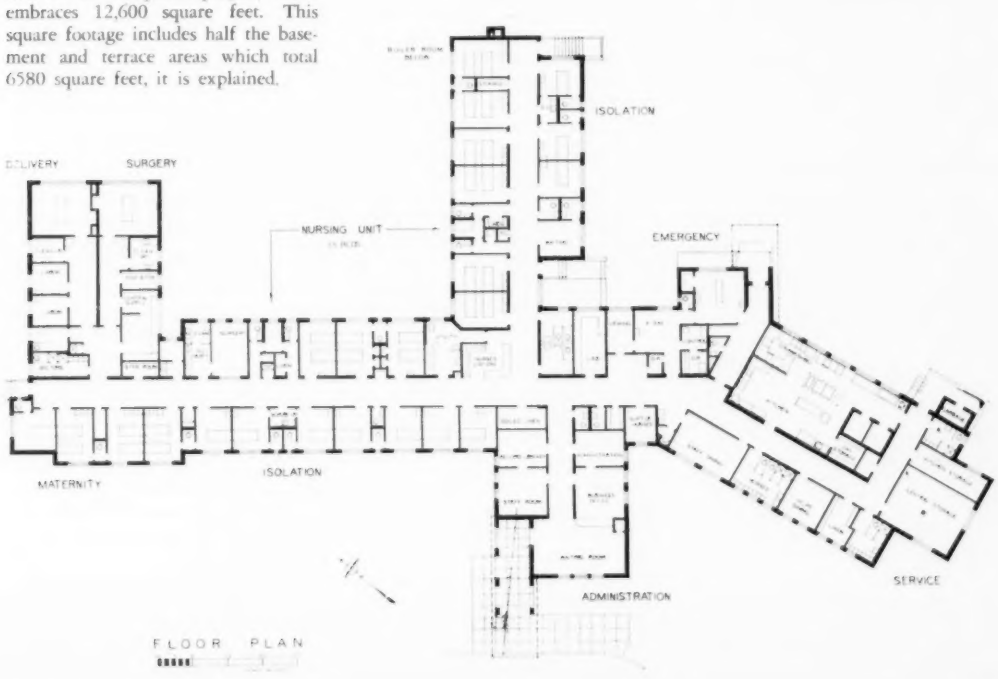
Surgical and obstetrical facilities are located side by side in one wing served by a single entrance off the main corridor, but separated so that the labor and delivery rooms are isolated from traffic to and from the surgery. Maternity and nursery facilities, however, are necessarily located along the corridor serving the surgical and central supply departments.

The heating plant is under the wing extending to the rear from the main entrance. The other basement area is under the operating and delivery rooms where air conditioning machinery is installed.

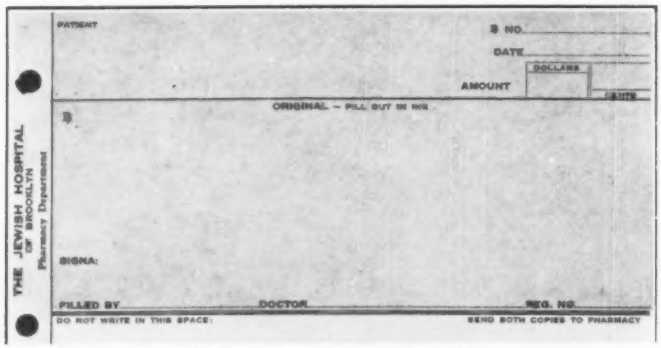
Total cost of the project was $278,887 for construction. Equipment costs were estimated by the architects at $42,000 with fees expected to approximate $16,390, making a total of $337,277 for the completed project, which embraces 12,600 square feet. This square footage includes half the basement and terrace areas which total 6580 square feet, it is explained.



The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month.



FLOOR PLAN



DUPLICATE REQUISITION—CHARGE VOUCHER

How to handle SPECIAL CHARGES

JOHN F. MILLER
Administrative Resident
Jewish Hospital, Brooklyn, N.Y.

A SYSTEM of handling special charges to patients' accounts has been developed at the Jewish Hospital of Brooklyn through the use of a duplicate "requisition—charge voucher." This system became necessary owing to the number of special charges received from the pharmacy department, although plans are under way to expand this system to include special charges from other departments, *e.g.* x-ray, laboratory, telephone and others. For the purpose of this article the pharmacy "prescription — charge voucher" will be discussed and only a modification of this form is necessary to adapt it to other departmental charges.

CONVENIENT FOR POSTING

The prescription — charge voucher is a duplicate form designed either for use with an identification plate or for hand writing. The original copy, which serves as the prescription and is retained by the pharmacy, is carbonized in such a manner that the pertinent descriptive information is transcribed onto the duplicate which serves as the charge voucher to be forwarded to the accounting department. Precautions should be taken to ensure a carbonizing process, such as a wax carbon, that will take a good impression when an ordinary pen is used and yet will not smear or rub off. The size of the form used is such that it is convenient for use with a posting machine; consequently the bottom portion of the form is not carbonized and is reserved for use by the accounting department.

The nurse or ward secretary may complete the top portion of the prescription either by using the identification plate or by writing in the patient's name, room number, hospital number, service and any other information that may be required by the accounting department. The rest of the prescription is completed by the physician, in ink, so that it meets with the federal narcotic regulations. At the Jewish Hospital, because of New York State laws, the physician completes the entire form.

Both copies of the prescription are forwarded to the pharmacy department in the daily drug baskets or by the hourly messenger service. (In a hospital that uses a pneumatic tube system the entire process can be speeded considerably.) The pharmacist or pharmacy clerk prices and serially numbers each prescription. The same number goes on a control sheet which is forwarded to the accounting department at the end of each day as a check on all pharmacy charges posted to patients' accounts. Two numbering machines are essential, one with a red pad to indicate narcotic prescriptions and one with a black pad for all other medications.

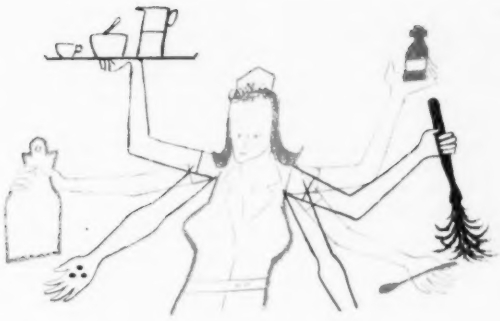
At intervals during the day, the messenger delivers accumulated prescriptions to the pharmacy department and on her return delivers those which have been filled to their respective units. On these rounds the messenger also takes the completed charge vouchers to the accounting department where they are sorted and stuffed into the patient's ledger. At a convenient time during the day these charges can be entered at one posting. This obviates pulling the patient's ledger card several times a day.

Inasmuch as the vouchers are continually being sent to the accounting department, it is reasonable to assume that on a patient's discharge all vouchers would be either posted to the patient's account or filed with his ledger card. However, to obviate the problem of late charges that do not appear on the patient's bill, it has been requested that the floor inform the pharmacy when a patient is being discharged or taking medication home so that the pharmacist can notify the accounting department by telephone. In these instances a notation is made on the charge voucher indicating that the charge has already been called into the accounting department.

ACCOUNT CAN BE ADJUSTED

When it becomes necessary to have a prescription refilled, a new prescription—charge voucher is completed and sent to the pharmacy accompanied by the empty container. In the event that medication, which may be reused, is returned to the pharmacy, a prescription—charge voucher is completed by the pharmacist and stamped "Credit." This is priced and the charge voucher is sent to the accounting department so that the proper adjustment can be made to the patient's account.

Several features of this system are readily apparent. First, much writing is saved on the nursing units through the use of the identification plate. Second, the pharmacy is relieved of writing innumerable charge slips and it is only a matter of pricing and numbering the prescription before the charge voucher is ready for forwarding to the accounting department. Third, the accounting department, in turn, is able to accumulate the charges in the patient's ledger for one daily posting and can refer to the daily control sheet to ensure that all vouchers have been posted. Fourth, by designing similar charge forms for the other departments mentioned, one can readily see a saving of labor and time that would offset the cost of form design and printing and at the same time obtain a control which would ensure that all charges have been posted to the patients' accounts.



St. Vincent's slogan

SHARE-THE-NURSE

meets with everybody's approval

RAYMOND P. SLOAN

ST. VINCENT'S Hospital in New York boasts two floors, one in its Spellman Pavilion and another in its recently opened Alfred Smith building, which are practically complaint-free as regards nursing care rendered. These are the floors where patients share private duty nurses under the "Share-the-Nurse" plan which, much to the satisfaction of patients, nurses, doctors, to say nothing of the hospital administration, is now in its fourth year of operation. As Sister Loretto Bernard, administrator of the institution, expressed it recently, in describing the pattern first introduced in March 1947—"My only hope is that some day we shall be able to apply it throughout the entire hospital."

"Share-the-Nurse" plans have been tried out with varying degrees of success in other communities, but none with such consecutive accomplishment and acclaim as that of St. Vincent's. The reason lies unquestionably in the period of preparation that preceded the inauguration of the system.

A study of nursing service in the hospital made in 1946 revealed a shockingly uneven distribution of nursing care. Certain staff nurses were overburdened to the point that they could not always render the service required, while elsewhere private duty nurses were caring for ambulatory patients. About that time, too, the District Nurses' Association increased the amount paid to nurses from $9 to $11 for an eight-hour day, which threatened to precipitate unemployment. Something had to be done. That something was to appeal to the private duty nurses to help distribute professional care more evenly among those patients requiring it.

A committee was appointed to study the matter. This comprised the hospital administrator, the director of nursing service, the chairman of the school of nursing committee, a consumer of nursing service, who was also a member of the women's board of the hospital, a member of the board of directors of the alumni association, the supervisor of the private pavilion, and two private duty nurses. They voted unanimously in favor of experimenting with a flexible nursing service for a period of six months, following which the project would be reviewed. The plan which today embraces two floors and which will ultimately, it is hoped, be applied to other floors is, with very few changes, the same as the original of four years ago.

Floor "8" in the Spellman building, to which the "Share-the-Nurse" idea was first applied, comprises 17 patients, for whom a nursing staff of 19 is provided. Eight nurses are on duty from 7:45 a.m. to 4 p.m., seven on duty from 3:45 p.m. to 12 midnight, and four from 11:45 p.m. to 8 a.m. One nurse is assigned to every two patients. An aide runs errands, takes routine temperatures, arranges flowers and attends to other details. A volunteer is also on the floor from 8 a.m. to 4:30 p.m. No staff nurses are present at any time.

For such half-time private nursing service, the patient pays $11 for 24 hour coverage—this, as against $33 for exclusive care. Should he become acutely ill, he receives the ministrations of one nurse exclusively, the responsibility for the allocation of such special service resting with the supervisor. As he improves, the patient's nursing service tapers off. It is clearly indicated, however, that should his condition require prolonged individual care, he should, if his financial condition permits, have special nurses, in which case, however, he must be transferred to another hall. For this reason cases involving brain surgery, or patients suffering mental disturbances are never assigned to these special nursing areas. Patients are admitted to units employing the "Share-the-Nurse" plan only if they accept the program in its entirety.

As evidence of the flexibility of the plan, a patient has the privilege of being transferred from a floor that has staff nursing service when special nursing service is indicated and of being

returned to a regular hall or unit when the need for such special care is no longer indicated.

There was the case of Mr. "X." Following 18 days on regular service, during which he underwent a clinical work-up in preparation for an operation, he was transferred from the surgery to Spellman "8." After five days of special nursing care, he was transferred, with his doctor's permission, to his original floor. In consequence, instead of paying $165 for three special nurses for five days' care, he paid only $55.

Was Mr. "X" pleased when he paid his hospital bill? Naturally. And he is only one of hundreds. The difficulty is that everyone wants to "Share-the-Nurse." There is always a waiting list for accommodations in Spellman "8," as well as in the newest unit in the Alfred Smith Pavilion. The records reveal only three complaints in more than four years, which is a record, indeed.

THE NURSES LIKE IT

When the plan was first outlined, the sponsoring committee wondered what would be the attitude of the nurses toward dividing themselves between patients. For this reason it was stipulated that the original group of nurses must stand by during the trial period of the first six months. Of the 10 private duty nurses who volunteered, nine remained after two and a half years of service. Of the nine staff nurses who wanted to go on the program, only two have resigned.

When the first private floor of the new Alfred Smith Pavilion was opened, it was assigned to the "Share-the-Nurse" plan. Immediate interest was manifest not only by the older nursing groups, but by the younger graduates. It became difficult even to get staff duty nurses for other floors in the same building. The fact that after two and a half years enough nurses were available for such service is in itself evidence that the girls like it. Today there is a waiting list of applicants.

Why do they like it? First, the "Share-the-Nurse" plan assures steady employment. The girls know where they stand. Salaries range from $200 to $250 per month, according to experience. And only those with experience are acceptable. Maturity, good judgment, dependability are essential qualifications.

Under the plan, nurses are assured one and a half days off each week, exclusive of nine holidays per year. Two weeks' vacation with pay is given at the end of one year, three weeks' at the end of two years, and four weeks' at the end of three years. Paid sick-time allowance is one week at the end of six months and two weeks at the end of a year. The girls also participate in any social security or pension plan provided by the hospital. At present this includes membership in the Blue Cross.

Each nurse has a choice of two out of three shifts, which means that she can plan her time six months in advance, knowing whether she will be on days, evenings or nights. All of this adds up to a regularity of life which heretofore has been notably absent from a nursing career.

Figures in the nursing administrator's office reveal that the girls like it. They like it, too, because they are doing the type of nursing they prefer. And they have the satisfaction of knowing that throughout the period of nursing shortage they have helped make available expert care to many more patients. They are also free from the pressure of service that exists on floors less well staffed, yet are spared the boredom often present on special duty with someone who is not acutely ill. Even though all beds on the floors are not occupied, a state of affairs which infrequently occurs, the nurses are not removed.

STAFF WAS SKEPTICAL

At the start, there was some doubt on the part of members of the medical staff as to the practicability of any such "Share-the-Nurse" plan; no more doubt, however, than was felt by other members of the committee. Once the plan got started, however, the staff members became more and more enthusiastic.

Why? They recognize the advantages of greater stability of the personnel, also the higher quality of the service rendered. They have found it less necessary to enter complaints with the administrator. Also, they have been relieved from the pressure of trying to provide special nurses for their patients.

They are now assured a place where the patient can be taken for an acute medical condition or where a post-operative case can be sent and receive expert nursing care around the clock for whatever number of days may be indicated—at the minimum cost. More important than the cost, even, is the assurance that the nursing service is of the highest quality for each 24 hours of the day. There is no slumping off at any time.

How can the success of this plan be measured from the standpoint of the hospital administration? The answer is self-evident: better patient care to those who cannot afford the cost of full-time individual attention.

The hospital gains little materially from such a service. Its recompense is in better care to the patient at lower cost. Patients in Spellman "8" receiving service under the "Share-the-Nurse" plan pay in the neighborhood of $5000 a month toward a pay roll of $4700. The balance is put aside for the benefit of the nurses and to provide for any emergency that may arise. Any deficit incurred is the responsibility of the institution.

TAKE GREATER INTEREST

Point two in favor of the plan, Sister Loretto Bernard describes as follows: "Better satisfied patients and doctors mean fewer problems. A stable staff in this, as in any other area of the hospital, effects economies in many ways. Less time is lost in orientation. There are more careful use of materials and better care of equipment, owing to greater interest on the part of the nurses in the unit.

"Our experience has shown this to be a most desirable pattern of nursing service for the hospital, and we are most anxious to extend it whenever the nursing personnel is available."

By nature conservatively cautious, yet extremely keen in appraising all hospital matters, particularly those involving nursing with which she has been closely identified for many years, Sister Loretto Bernard tempers her enthusiasm with notes of warning for those who would embark upon such a program.

Much depends upon the supervisor. It is she who must evaluate the nursing needs of her unit, be ready to meet the difficult situation, and make sure that the nursing load does not fall too heavily upon certain individuals. There is always the possibility of one patient feeling that the nurse is "playing favorites," and that he is on the losing side. St. Vincent's records show few such complaints, as strange as it may seem.

The supervisor must be an efficient administrator, possessed of good judgment, the ability to get along with all

types of people, and must display the leadership that will assure her the loyal support of her staff and the confidence of doctors and hospital administration alike. It is no simple matter to find one individual so endowed, but it is important, before taking the first step.

Also, before starting a "Share-the-Nurse" program, precautions should be taken to assure the proper number of nurses. There should be one nurse per patient. These nurses, too, should be mature and thoroughly capable. The first 10 private duty nurses that St. Vincent's signed up for Spellman "8" had 10 years of nursing behind them.

Experience has likewise proved that it is unwise to attempt to operate two kinds of service on the one floor. It must be one plan or the other.

Success or failure rests with the manner in which the plan is explained or "sold" to the patient on admission. He should be given an accurate idea of how it operates and what he can or should not expect. This will help materially in eliminating any later misunderstandings.

An important factor in the progress made at St. Vincent's in developing its program was the committee which sponsored the plan and which continues to meet to discuss problems that arise from time to time. Without such guidance and interest, it is unlikely that "Share-the-Nurse" would be as popular a term as it is today with patients, nurses, doctors and hospital administration.

To return to the patients, where hospital service should always start and end, they are happy for many reasons. Mr. "X," referred to previously, still talks about what that hospital bill of his would have been but for the "Share-the-Nurse" plan. Mrs. "Y," on the other hand, is grateful because she has not been subjected to the frequent changes in nursing personnel that she experienced formerly in a service made up of students and graduates. "Mr. "Q" confides that whereas previously he had always had "specials," he became weary of having them about, particularly when he didn't have need of their constant surveillance and attention. "It's wonderful to have some time to yourself, time to read, time to write, time to remain quiet and not feel under any obligation to talk," is the way he puts it.

So everybody at St. Vincent's is enthusiastic over the "Share-the-Nurse" plan, everybody, that is, with the exception of those who cannot get in either Spellman "8" or the Alfred Smith unit, and who must be told that their names will be placed on the waiting list. Mr. Public doesn't mind queueing up for a good show, or a bang-up meal, but when it comes to hospital service, he wants it when he needs it.

However, if Sister Loretto Bernard has her way, he won't have to wait too long. One of these days St. Vincent's will provide further opportunities to "Share-the-Nurse."

Community Relations Can Be Improved

if Blue Cross and hospitals work together

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DISCUSSION of improved community relationship through joint Blue Cross and hospital activity necessarily assumes that there has not been sufficient cooperative effort on the part of Blue Cross and hospitals during times past. Even though hospitals themselves have long been in existence, primarily because of their public service function, and have by necessity maintained a public relations program which they have directed toward their communities, the Blue Cross program has only comparatively recently become effective. Blue Cross has followed hospital leadership in some instances and at times has traveled a solitary road, and the joint efforts of both to establish adequate community relations have not been of sufficient value to result in any particular benefits to either hospitals or Blue Cross, or both.

Blue Cross is just as necessary to hospitals today as is the department of surgery within a general hospital, and certainly it is as necessary as is the cashier's office or the credit department. Therefore, it follows logically that Blue Cross can well be considered a "sales agency" for hospitals. I do not think that Blue Cross is necessary to hospitals in order to keep beds filled because I am certain that the normal needs of any community would require the use of hospital beds whether Blue Cross existed or not. But I do think of Blue Cross as a service arm of hospitals, providing a means by which it is possible for people to prepay, and for hospitals to be reimbursed for services rendered to people who have had the foresight to make hospital care so readily available. Therefore, there must be a joint effort in presenting each other to the communities we serve in the best possible manner. This can well be done through the proper preparation of explanatory Blue Cross literature directed toward members and prospective members, and through hospital encouragement in establishing acceptance of the Blue Cross principle, and certainly complete approval of the program that is being presented. Such a program of joint effort on the part of hospitals and Blue Cross can only result from a mutual understanding of the benefits to be derived by the community from cooperative effort, and will, of course, be to the good of all concerned.

To effect a good working arrangement between Blue Cross and hospitals there must be a proper financial relationship so that hospitals will want to make the prepayment program available to their patients. It is also most important that good hospital service be available in behalf of Blue Cross members. It follows that, these things being equal, Blue Cross effort in a community must be approved and aided by all hospitals.

From a paper presented at the Tri-State Hospital Assembly, May 1950.

It is an accepted principle that hospitals should carry the responsibility of recommendation and leadership in matters of community health interest. Blue Cross, by the very nature of its service program, must be in a position of interpreting hospitals to the communities they serve and, having done so, must accept adequate financial responsibility for services rendered. After all, what good is Blue Cross if people can only understand dollars and not a program of service benefits? What good is Blue Cross if people do not believe in their own community hospitals and instead seek care elsewhere? What good is Blue Cross if Blue Cross sells hospital services at less than cost and as a result can only serve to the detriment of hospitals and ultimately to the detriment of Blue Cross itself in terms of curtailed hospital service? Therefore, I feel that Blue Cross must carry its own responsibility and price its certificates of protection on a basis that makes its program self-supporting and also makes it possible for hospitals to continue to provide comprehensive hospital service. Blue Cross and hospital cooperation in these matters can only result in community approval expressed in terms of increased Blue Cross membership and appreciation of hospital service.

Our next consideration is to seek joint development in our community approach. Development of good will is of paramount importance to both Blue Cross and hospitals. Good will is dependent upon understanding, understanding is dependent upon knowledge, and knowledge is dependent upon proper dissemination of information in a way that is easy for the public to assimilate. Here is the opportunity for Blue Cross to repay hospitals in part for the years of nurturing at hospitals' expense during its formative period.

It can do so by assisting the hospitals in developing community appreciation and pride through good public relations, through good sales efforts, and through the development of hospital understanding of Blue Cross benefits. The results of these efforts will be community recognition of hospitals and their part in making an adequate prepayment program available. It also follows that hospitals can assist Blue Cross in its program of good public relationship, good sales efforts and proper development of understanding of benefits by giving complete approval of Blue Cross as being the hospitals' own program.

In entering into a joint program we must be careful that we do not step on one another's toes. This warning is directed to hospital administrators and trustees against becoming too active in determining policies and procedures of Blue Cross, and to Blue Cross against placing itself in a position of determining what hospital policy and procedure must be. In other words, we must never find ourselves in a position of telling the other fellow what he must do. Further, we must work together to assure careful consideration of each other's problems without airing discussions in the public press as has been done recently to the detriment of Blue Cross and hospitals, undermining public confidence in our ability to work together. Bitterness has no place in good business relationship, and public expressions reflecting distrust and need for protecting the community against either hospitals or Blue Cross cannot be condoned.

Pay patients like hospitals and hospitals like pay patients. Therefore, we must join our efforts in raising and maintaining Blue Cross enrollment in a community because of benefits to all three: the hospital, the patient and Blue Cross. We must also work together to develop medical appreciation of our combined efforts so that necessary cooperation on the part of the medical profession will be present to assure the provision of maximum benefits to both the hospital and the patient without abuse, and to assure actuarial soundness of Blue Cross.

How can Blue Cross develop so that it will serve the hospitals better? I believe that Blue Cross will ultimately include as a part of membership fees adequate provision for expansion of hospitals themselves; that it will enter the field of preventive medicine even as hospitals are entering today. I believe, too, that Blue Cross will have to make its facilities available to hospital associations to assist in programs of interest to hospitals, such as nurse recruitment and governmental relations, and that it will have to furnish statistics concerning types of hospital service that will be helpful in planning hospital building programs to assure the provision of adequate facilities.

Unquestionably, Blue Cross members go to hospitals earlier than do the majority of other patients, and they have a wider scope of care available because of freedom from the economic barriers. It would seem to me that we, hospitals and Blue Cross, must constantly study and develop better methods of assisting one another in seeking to serve our communities better. We must cooperate in ventures to our mutual good and we must constantly seek new areas of service. We must recognize the need of community appreciation of our joint efforts if we are to be enabled to continue in the voluntary way.

NOTHING BUT THE TRUTH!

THE natural justification for telling an untruth is that this is a protective mechanism in the struggle for existence. Some people would, indeed, perish without delay if they realized the truth about themselves! Some actually need to be untruthful at times while others must lead themselves into thinking that they must be. Some lie and survive while others, consciously or unconsciously, fail to lie and go under. Sickness, medication, individuals and circumstances have much to do with this phenomenon at any time and particularly in a hospital.

The hospital executive dealing with an infinite variety of personnel, guests, relatives, friends and the miscellaneous public must not generalize and treat alike all those who stray more or less from the path of virtue. In situations like these his judicial talents must come into play, for they are worth more than his executive and legislative talents put together. One employe may know better than to be untruthful, another should know better, a third can be guided to know better, and a fourth may or may not be hopeless.

In situations like these, patience is required of the executive to a greater extent than is required of the subordinate staff. The search for truth is a search for the ideal. Severity is justified only when the safety and the comfort of the sick are involved, or the liar is incorrigible or pathological.—E. M. BLUESTONE, M.D.

What It Costs to Educate Nurses

in liberal arts colleges

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BUSINESS managers may be interested in a report of a recent study on the costs of nursing education in liberal arts colleges because it describes the methods of computing costs and points out some of the limitations of the methods and the problems involved in cost computations. Some of the administrative implications to a college embarking upon a program of nursing education for the first time are presented. The results of the computations, also, may be of interest.

The study was made in three liberal arts colleges, two coeducational institutions enrolling approximately 600 and 1000 students each, the third a women's college enrolling a little over 400 students. The programs were four-year professional courses leading to the B.S. degree with a major in nursing. Both the academic course work given on the campuses of the colleges, and also the clinical training given in affiliating hospitals under the supervision of the colleges are involved.

Costs were computed for the colleges for the fiscal years 1946-47, 1947-48, and 1948-49, and for the hospitals for only one year, 1948.

PROCEDURES

The determination of costs for providing educational programs, especially as expressed in costs per student, is a complex and involved procedure. Standard technics have been developed for these computations and have been reported by the National Committee on Standard Reports in its volume published in 1935. Many factors involved in educational institutions, however, do not lend themselves to exact mathematical treatment. The problem is far different from the determination of unit costs of production or operations in business and industry.

Procedures for the Colleges. In computing costs in colleges, three groups of expenditures are involved:

1. Direct expenditures for the nursing department. These expenditures usually are easy to identify, inasmuch as college budgets generally are prepared on a departmental basis, and expenditures for each department are recorded in separate accounts. Table 1 shows this group of expenditures for the three colleges that are involved in the present study.

2. Expenditures for the instruction of nursing students in nonprofessional courses. Some of the required work of the nursing students is in nonprofessional courses in which both nursing students and students from other departments are registered. The most nearly accurate method of determining the amount of these expenditures to be included in computing costs for nursing education, as described by the national committee, calls for a detailed allocation of expenditures for instructional salaries, supplies, materials,

Table 1—Direct Budget Expenditures for Nursing Departments

	College A			College B			College C		
	1946-47	*1947-48*	*1948-49*	*1946-47*	*1947-48*	*1948-49*	*1946-47*	*1947-48*	*1948-49*
Salaries	$ 7,892	$11,758	$13,304	$17,743	$20,408	$23,972	$18,327	$20,925	$19,030
Administration	580	1,341	395						
Supplies	391	600	516	426	580	834	1,206	371	609
Transportation to and from affiliating hospitals	561	447	300	2,703	2,574	2,039	599	208	280
Faculty travel	200	263	428				639	883	720
Group hospitalization fees				446	285	516	23	452	189
Equipment	355	1,826	1,383	1,716	3,309	6,041	7	2,091	645
Miscellaneous	942	1,357	447	550	500	500	1,461	1,287	1,141
Scholarships				4,090	2,550	1,500	500	2,150	2,813
Total	$10,921	$17,592	$16,773	$27,674	$30,196	$35,402	$22,762	$28,367	$25,427

Table 2—Computation of Nonprofessional Instructional Charges for Nursing Students

	Total Instructional Expenditures	*Total College Enrollment on Campus*	*Instructional Cost per Student*	*Number of Nursing Students on Campus*	*Amount Charged to Nursing Students*
COLLEGE A					
1946-47	$139,206	870	$160.00	10	$ 1,600
1947-48	170,806	952	179.41	27	4,844
1948-49	180,369	999	180.55	25	4,514
COLLEGE B					
1946-47	98,137	432	227.17	35	7,951
1947-48	122,809	432	284.28	43	12,224
1948-49	137,467	432	318.21	46	14,638
COLLEGE C					
1946-47	131,005	540	242.60	10	2,426
1947-48	183,960	627	293.40	25	7,335
1948-49	218,556	624	350.25	27	9,457

equipment, library services, and the operation and maintenance of the physical plant. Because data were not available to make this extremely detailed allocation, costs were computed for the nonprofessional instruction of nursing students by applying the average cost per student for the instructional function of the college as a whole to the number of nursing students on campus, excluding those under instruction and living at the hospitals. The figures in table 2 illustrate these computations.

3. Expenditures for "overhead," that is, for the general administrative functions, the library, and the operation and maintenance of the physical plant. In detailed computations, appropriate charges would be made to the nursing program for its share of these expenditures on the basis of budget expenditures for the department, number of students enrolled in the department, student credit hours taught in the department, square foot hours of space used by the department, or on combinations of these factors. In the present study, because of the lack of data necessary to follow more detailed and accurate technics, overhead expenditures were allocated to the nursing department on the basis of the number of nursing students on campus, again excluding those under instruction and living at the hospitals. Table 3 illustrates these computations.

Procedures for the Hospitals. The costs in the hospitals were computed on the basis of the methods developed by the U.S. Public Health Service in its study of costs for schools of nursing during the cadet nursing program, and described in detail in the bulletin, "Cost Analysis for Schools of Nursing, a Manual of Methods and Procedures," published by the Federal Security Agency, U.S. Public Health Service, Washington, D.C.

The following categories of expenditures were first set up in these cost studies: insurance on buildings and equipment, repairs and replacements, administration, plant operation, housekeeping, laundry, dietary, maintenance (that is, housing) of student nurses, and instruction of student nurses. A final category was set up for the main function of the hospital, that is, the care of the sick.

As many as possible of the expenditures of the hospital were charged directly to these categories. After that, allocations were made from one category to the others on the following bases:

1. Building and equipment insurance, repairs and replacements, plant operation, and housekeeping expenditures were allocated on the basis of the areas involved in the maintenance and the instruction of student nurses as related to the total square foot area of the hospital plant. The space involved in the instruction of the student nurses would be any rooms or laboratories in the hospital used for this work.

2. Administration was allocated on the basis of the relation of the direct salaries in the various categories to total salaries in the hospital.

3. Dietary expenditures were allocated on the basis of the number of meals served the student nurses (and college personnel, as was the case in one hospital) and the average cost per meal.

4. Laundry expenditures were allocated on the basis of the relation of the laundry work performed for the student nurses to the total volume of laundry work performed for the hospital.

The analysis work sheet for one hospital, shown in table 4, will illustrate the application for these methods. The measurements of space, analysis of salaries, and computations for the dietary and laundry departments were done by the hospitals for other purposes, and therefore the detailed data were available for the present study.

COMPUTATIONS OF COSTS

Two types of costs were computed. The first was that of the avoidable costs, that is, the out-of-pocket expenditures and other charges which would not have been made, and therefore would have been avoided, if the nursing education programs had not been offered. These costs are based on the assumption that the other expenditures of operation in both the colleges and the hospitals would have continued at the same level.

The second type of cost was the total cost, involving both the avoidable costs as described and proportionate shares of all other expenditures of the colleges and hospitals.

Avoidable Costs in the Colleges. The figures in table 5 show the direct budget expenditures for the nursing departments and also charges for the

Table 3—Computation of Overhead Charges for Nursing Students

	College A			College B			College C		
	1946-47	1947-48	1948-49	1946-47	1947-48	1948-49	1946-47	1947-48	1948-49
Total college enrollment	870	952	999	432	432	432	540	627	624
Nursing students at hospitals	59	21	10	78	45	24	70	30	18
Total students on campus	811	931	989	354	387	408	470	597	606
Total nursing department enrollment	69	48	35	113	88	70	80	55	45
Nursing students at hospitals	59	21	10	78	45	24	70	30	18
Nursing students on campus	10	27	25	35	43	46	10	25	27
Ratio of nursing students on campus to total students on campus	1.23%	2.90%	2.53%	9.89%	11.11%	11.27%	2.13%	4.19%	4.46%
Total expenditures in college for:									
Administration	$ 74,465	$ 95,124	$ 98,327	$ 55,794	$ 72,253	$ 75,009	$ 48,690	$ 71,744	$ 80,873
Libraries	7,051	9,840	11,375	8,042	8,488	9,927	3,795	6,583	9,683
Plant operation and maintenance	85,761	109,951	122,917	61,682	73,719	99,758	20,198	27,114	33,720
Total	$167,277	$214,915	$232,619	$125,518	$154,460	$184,694	$ 72,683	$105,441	$124,276
Amount charged to nursing students	$ 2,057	$ 6,233	$ 5,885	$ 12,414	$ 17,161	$ 20,815	$ 1,548	$ 4,418	$ 5,543

Table 4—Allocation of Costs at "C" Hospital

	Insurance	Repairs and Replacements	Administration	Plant Operation	Housekeeping	Laundry	Dietary	Nursing Maintenance	Nursing Education	All Others	Total
DIRECT CHARGES											
Salaries		$ 1,870.31	$23,888.94	$ 7,324.39	$12,574.67	$ 8,746.02	$24,325.15	$ 3,060.00	$ 711.14	$135,684.94	$218,185.56
Supplies		2,226.72	5,194.91	1,197.48	5,634.80	1,523.38	1,200.88			41,482.15	58,460.32
Food							50,524.98				50,524.98
All others	$133.87	17,601.13	1,329.72	12,391.60	3,489.18			30.40	3,644.84		38,620.74
Total, Direct Charges	$133.87	$21,698.16	$30,413.57	$20,913.47	$21,698.65	$10,269.40	$76,051.01	$ 3,090.40	$ 4,355.98	$177,167.09	$365,791.06
ALLOCATED CHARGES											
Insurance	$133.87		$ 4.95	$ 3.88		$ 6.02	$ 8.43		$ 1.34	$ 109.25	$ 133.87
Repairs and replacements		$21,698.16	737.74	564.15		867.93	1,215.10	2,234.91	195.28	15,883.05	21,698.16
Administration			$31,156.26	1,183.94	$ 2,025.16	1,402.03	3,894.53	498.50	124.62	22,027.48	31,156.26
Plant operation				$22,665.44		974.61	1,359.93	2,470.53	226.65	17,633.72	22,665.44
Housekeeping					$23,723.81			2,894.30	260.96	20,568.55	23,723.81
Laundry						$13,519.99		1,014.00		12,505.99	13,519.99
Dietary							$82,529.00	4,456.57		78,072.43	82,529.00
								$16,659.21	$ 5,164.83	$343,967.56	$365,791.60
PERCENTAGES FOR ALLOCATION—											
Insurance			3.7%	2.9%	*	4.5%	6.3%	**	1.0%	81.6%	100.0%
Repairs and replacements			3.4	2.6	*	4.0	5.6	10.3%	0.9	73.2	100.0
Administration				3.8	6.5%	4.5	12.5	1.6	0.4	70.7	100.0
Plant operation					*	4.3	6.0	10.9	1.0	77.8	100.0
Housekeeping								12.2	1.1	86.7	100.0
Laundry								7.5		92.5	100.0
Dietary								5.4		94.6	100.0

*No allocations of insurance, repairs and replacements, and plant operation were made to housekeeping because that function occupied no special space.
**Insurance expense for nursing maintenance was charged directly to that function because the student nurses occupied a separate building. The amount of $30.40 reported under direct charge was the premium for one year on the nurses' home.

nonprofessional instruction of the nursing students. Although this item is not a direct budget expenditure of the nursing department, it is considered an avoidable cost because a group of 20 to 30 students in a college makes it necessary to organize and staff at least one additional section in such courses as English, mathematics, basic sciences, and other similar general college courses. For the purpose of this computation, it is assumed that savings would have been made in instructional expenses somewhere in the colleges in about the same amounts as charged the nursing departments if there had been no nursing students on the campus.

Avoidable Costs in the Hospitals. Inasmuch as accounting systems of hospitals are not generally set up to record direct expenditures for either the housing or the instruction of nursing students, it was necessary to obtain the best possible estimates of the expenditures which would have been saved if the hospitals had not participated in the programs with the colleges. These estimates were obtained from the administrative officers and others in the hospitals who had contact with, and information about, the programs and work of the nursing students. Table 6 shows the items and amounts of expenditures which probably would have been saved if the student nursing programs had not been in operation in the hospitals, as estimated by the hospital officers and staff members.

By combining the figures in these tables 5 and 6, as shown in table 7, it would seem that the programs of nursing education caused an out-of-pocket expenditure to the colleges and hospitals of approximately $1000 per nursing student in 1948.

Total Costs in the Colleges. Table 8 summarizes the total expenditures and charges for the nursing programs in the three colleges. The costs per student also are shown.

These figures show that although enrollment in the colleges increased somewhat during the three-year period (or was held constant as was the case in one college), enrollment in the nursing departments decreased, while direct budget expenditures and total expenditures and charges for the nursing department increased. The costs per student increased greatly, which is the inevitable result from the action of the two factors involved in the computations.

A word of explanation, probably, is

Table 5—Avoidable Costs in the Colleges

	Nursing Students	Direct Budget Expenditures	Non-professional Instructional Charges	Total Expenditures and Charges	Costs per Student
COLLEGE A					
1946-47	69	$10,921	$ 1,600	$12,521	$181
1947-48	48	17,592	4,844	22,436	467
1948-49	35	16,773	4,514	21,287	608
COLLEGE B					
1946-47	113	27,674	7,951	35,625	315
1947-48	88	30,196	12,224	42,420	482
1948-49	70	35,402	14,638	50,040	715
COLLEGE C					
1946-47	80	22,762	2,426	25,188	315
1947-48	55	28,367	7,335	35,702	649
1948-49	45	25,427	9,457	34,884	775

Table 6—Avoidable Costs in the Hospitals—1948

	Hospitals Affiliating With		
	College A	College B	College C
Salary of residence director	$ 1,240	$ 1,000	$ 1,200
Salary differential for director of nursing services		1,000	
Payment to colleges for services of nursing students	3,769	5,948	3,645
Hospital supplies and miscellaneous expenses	869	150	
Compensation insurance		84	31
Dietary department expenditures	3,201	7,391	3,990
Laundry, 1 employe		1,440	1,332
Operation and maintenance expenditures in housing facilities for nursing students	1,281		1,235
Miscellaneous expenses in laundry, dietary, and housekeeping departments	1,000	1,640	860
Total	$11,360	$18,653	$12,293
Number of nursing students at the hospitals	21	45	30
Avoidable Costs per Student	$541	$415	$410

Table 7—Combined Avoidable Expenditures, and Avoidable Costs Per Nursing Student

	College A		College B		College C	
	Amount	Per Student	Amount	Per Student	Amount	Per Student
In Colleges	$22,436	$ 467	$42,420	$ 482	$35,702	$ 649
In Hospitals	11,360	541	18,653	415	12,293	410
Combined	$33,796	$1,008	$61,073	$ 897	$47,995	$1,059

desirable on the figures for 1946-47. During this year the cadet nursing program supported by the federal government was in the process of being terminated, and the colleges actually began in the next year to adjust their programs and establish their own collegiate departments of nursing education. Too much emphasis, therefore, should not be given to the figures for 1946-47.

Total Costs in the Hospitals. Table 9 shows the expenditures for the year 1948 in the affiliating hospitals as determined by the procedures described in the bulletin of the U.S. Public Health Service. The costs per student living and working at the hospitals are shown also.

By combining the figures for 1947-48 in the colleges with those for 1948 in the hospitals, as shown in table 10, it is seen that the combined annual cost per student for the total activity of the program is about $1500.

Limitations of the Study. Several criticisms and limitations of the study are apparent. In computing the avoidable costs in the colleges, it was assumed that had there been no nursing students on campus instructional expenditures would have been reduced by the amount of the charge for nonprofessional instruction of the nursing students. The validity of this assumption is doubtful, inasmuch as it is almost certain that the places of the nursing students on the campus would have been filled by other students.

The avoidable costs reported for the hospitals are, for the most part, estimates, rather than actual expenditures as reflected in the books of account in the hospitals.

Lack of basic data and information at the colleges necessary to follow the standard procedures described by the national committee made it necessary to follow less detailed and exact methods in determining total expenditures and in computing unit costs based thereon.

The methods of computing costs in the hospitals are designed primarily for schools of nursing conducted by hospitals, in which the supervision and administration of the instructional work for the nursing students are performed by the hospitals. This procedure, designed for cost computations in noncollegiate programs, is not the most satisfactory procedure for collegiate programs in which practically all the supervision and administration of the programs of training are done by the faculty and officers of the college. In the absence of any other methods, the procedure of the U.S. Public Health Service had to be followed.

The number of students involved in the various computations was not the same. In computing the charge for nonprofessional instruction, the number of students in the three colleges for which the charge was made is 27, 43 and 25, respectively; the number involved in computing the over-all per student costs is 48, 88 and 55, and the number used in computing the costs at the hospitals is 21, 45 and 30.

The fiscal periods covered in the combined figures are not the same; those for the colleges were from July 1, 1947, to June 30, 1948; those for the hospitals were from Jan. 1, 1948, to Dec. 31, 1948.

Other limitations and criticisms could be mentioned. It is felt, however, that the figures reported here give approximations of expenditures and rates of costs which would be typical of collegiate programs for nursing education in liberal arts colleges.

ADMINISTRATIVE IMPLICATIONS

Some of the administrative implications coming from this study which should be considered by a college that is thinking of embarking upon a pro-

gram of nursing education for the first time are:

1. What should the enrollment be in a department of nursing? The figures in the present study indicate that, as student enrollments decrease, the unit costs of offering the programs increase. From the point of view of operating an instructional program at the lowest possible unit cost, the largest possible number of students should be enrolled. Small classes cause high unit cost, and probably indicate an uneconomical use of college funds. However, unreasonably large classes do not contribute to the best instructional results, especially in professional work involving specialized courses such as nursing arts.

Administratively, colleges should avoid both unreasonably small and also unreasonably large enrollments in this department, and the total enrollment in the department should not be out of proportion in size to the other instructional departments in the college.

2. Availability of space and facilities. Nursing education involves instruction in chemistry, biology, dietary procedures and nursing arts, each of which involves specialized facilities and equipment. Most liberal arts colleges today offer work in the sciences, and usually will not find it necessary to set up and equip laboratories for chemistry and biology. Some colleges offer work in home economics, and therefore the problem of providing adequate instructional space for the work in dietary practices will not entail a large financial outlay. However, the provision of a nursing arts laboratory usually will mean substantial expenditures in getting a nursing program under way. Furthermore, if the facilities already available in the other sciences are now used to such an extent by other students that the nursing students cannot have adequate use, the problem of expense in providing additional facilities may be significant.

In the colleges included in this study, expenditures for setting up the program varied, depending upon the available facilities. In one institution a total of approximately $4000 was reported as the only cost in setting up the program, since all the necessary laboratory and classroom space was available and easily adapted to the use of nursing students. The second institution reported expenditures of approximately $40,000 in setting up and equipping the laboratories and space for nursing students. A completely

Table 8—Summary of Total Expenditures and Costs in Colleges

	Enrollment		Direct Budget Expenditures	Non-professional Instructional Charges	Overhead Charges	Total Expenditures and Charges	
	Total	Nursing Students				Amount	Per Student
COLLEGE A							
1946-47	870	69	$10,921	$ 1,600	$ 2,057	$14,578	$ 211
1947-48	952	48	17,592	4,844	6,233	28,669	597
1948-49	999	35	16,773	4,514	5,885	27,172	776
COLLEGE B							
1946-47	432	113	27,674	7,951	12,414	48,039	425
1947-48	432	88	30,196	12,224	17,161	59,581	677
1948-49	432	70	35,402	14,638	20,815	70,855	1,012
COLLEGE C							
1946-47	540	80	22,762	2,426	1,548	26,736	334
1947-48	627	55	28,367	7,335	4,418	40,120	729
1948-49	624	45	25,427	9,457	5,543	40,427	898

Table 9—Summary of Total Expenditures and Costs in Hospitals—1948

	Hospitals Affiliating With		
	College A	College B	College C
Maintenance of Student Nurses:			
Salaries	$ 1,240	$ 1,568	$ 3,060
Supplies		183	
Insurance	32	133	30
Repairs and replacements	1,281	1,186	2,235
Administration	243	166	498
Plant Operation	2,917	4,788	2,471
Housekeeping	2,290	3,585	2,894
Laundry	1,217	1,315	1,014
Dietary	5,662	13,501	4,457
Subtotal	$14,882	$26,425	$16,659
Instruction of Student Nurses:			
Salaries	$ 798	$ 3,290	$ 711
Supplies	869	30	
Insurance	6	5	1
Repairs and replacements	223	50	195
Administration	156	354	125
Plant operation	648	1,195	488
Subtotal	$ 2,700	$ 4,924	$ 1,520
Payments to Colleges*	$ 3,769	$ 5,948	$ 3,645
Total Expenditures	$21,351	$37,297	$21,824
Number of Student Nurses	21	45	30
Cost per Student Nurse	$ 1,017	$ 829	$ 727

*At one institution the amount of payment was reduced to a rate per day. It was based on the salary of a graduate nurse and the equivalent value of the student nurses in relation to a full-time graduate nurse. At this college they figured that the student in the first part of her second year was equal to 67 per cent of a graduate nurse and her services were worth 74 cents per hour. In the second part of this year, the student nurse was worth 80 per cent of a graduate nurse and the monetary equivalent was 88 cents per hour. Actual hours of work were computed for the student nurses at this hospital and appropriate deductions from total hours were made for classroom work and field trips. Another deduction was made for the value of the maintenance given to the student nurses and the resulting value of the work of a student nurse during the whole year was reduced to an amount per day, which, in this case, was $1.38.

Table 10—Combined Total Expenditures, and Total Costs per Student

	College A		College B		College C	
	Amount	Per Student	Amount	Per Student	Amount	Per Student
In Colleges	$28,669	$ 597	$59,581	$ 677	$41,120	$ 729
In Hospitals	21,351	1,017	37,297	829	21,824	727
Combined	$50,020	$1,614	$96,878	$1,506	$61,944	$1,456

new dietary kitchen and nursing arts laboratory were necessary here. The third college reported initial expense of a little more than $16,000 primarily for the remodeling of space for the nursing arts laboratory and dietary kitchen.

3. Position of the faculty and department of nursing within the college. Specialists in teaching the nursing arts and dietary practices for nursing students are necessary. However, these professors, from the college point of view, should be integrated with the other faculty members. Their positions and salaries should be comparable with those of other faculty members having the same or equal training and responsibility.

The nursing department should be recognized and accepted by the college as a collegiate department leading to an academic degree on the same basis as the other departments in the college. It should not be looked upon as a subcollegiate, semi-trade school program which does not have respectable academic standing with the other departments in the institution.

4. Availability and adequacy of hospital training facilities. Hospitals affiliating with collegiate programs should be selected which are reasonably close to the college, and which are able to provide adequate experience and training for the students in all the clinical fields. In the present study the costs of transportation in one college were substantially higher than were those in the other two simply because the hospital used by that college was at a considerable distance from the campus.

In another college the expenditures of the affiliating hospitals were higher than in the others because it was necessary to use two hospitals to provide experience and training in all the clinical fields rather than one, as was the case in the other two colleges.

The affiliating hospital will want to consider several factors as plans go forward for a new program. In the first place, a steady supply of nursing students should be available to the hospital each year. A number has been suggested of 20 student nurses a year for a hospital of approximately 100 beds having adequate clinical facilities. If the college is to furnish this number, the enrollment in the department of nursing should be not less than 80, while an enrollment of 100 students probably would be better.

In the second place, consideration should be given to the availability of housing facilities for student nurses at the hospital. If new facilities for this purpose must be acquired and provided by the hospital, or if extensive remodeling or adapting of present space must be done, the initial cost to the hospital of getting the program under way will be high.

Finally, careful consideration should be given to the services of the student nurses at the hospitals. A willingness on the part of the hospital to give the nursing students the proper amount and type of work, so that they will gain real educational value and experience, should be evident in selecting an affiliating hospital. Student nurses should not be exploited; their period of "internship" should be put on the highest possible level of professional training.

VOLUNTEER ACTIVITIES

Mrs. Tuttle Is Chairman

Mrs. L. L. D. Tuttle of Houston, Tex., has been appointed chairman of the Committee on Women's Hospital Auxiliaries of the American Hospital Association, according to Dr. Charles F. Wilinsky, president.

Mrs. Tuttle succeeds Mrs. Amos F. Dixon, Stillwater, N.J., who has served as chairman for the two years the committee has been organized. Mrs. Dixon continues as a member of the committee.

With a long period of hospital auxiliary experience, Mrs. Tuttle is prepared to assume the national leadership. Her own hospital auxiliary is the Methodist Hospital, Houston, of which she was president four years, 1944-48. Thereafter, she was elected president of the Texas Association of Hospital Auxiliaries, serving from 1948 to 1950. In 1948 she was national chairman of the women's section for the annual meeting of the National Board of Methodist Hospitals and Homes held in Cincinnati, Ohio.

Mrs. Tuttle was appointed to the Committee on Women's Hospital Auxiliaries, American Hospital Association, in 1949, following the Cleveland convention, when Type V institutional membership (women's hospital auxiliaries) was established. There are close to 500 hospital auxiliaries holding Type V membership in the A.H.A.

Women Are Warned

Some warnings to members of women's auxiliaries were sounded by Dr. Wilmar M. Allen, administrator of Hartford Hospital, in addressing representatives of women's groups at the Atlantic City convention in September.

Problems in human relations frequently arise between hospital staff and auxiliary workers, Dr. Allen declared, and pointed out five of them.

1. The auxiliary that apparently presents the administrator no problem, raising money for the institution but having no real contact with it. Its members do not serve as volunteer workers, conduct a gift shop, or operate a snack bar.

2. Auxiliary members who work as volunteers and who discuss confidential matters picked up in the hospital at public gatherings or in their own circle.

3. Members of auxiliaries, especially wives of trustees or of medical staff men, who attempt to propagandize and exert pressure on the administration.

4. Volunteer workers who can't get along with nurses and other hospital employes or who become involved in administrative matters.

5. Cliques that develop within a single auxiliary, such as summer colony predominance at resort centers.

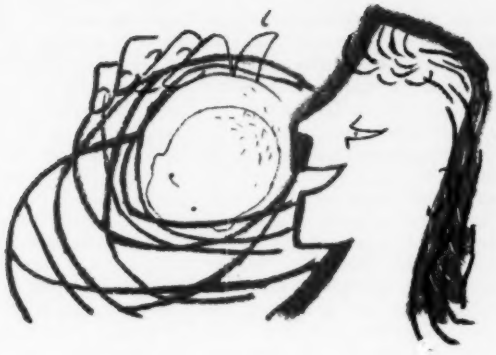
"The work of auxiliaries must be carefully defined to avoid such difficulties," Dr. Allen asserted. By-laws must clearly define the purposes, making it plain that trustees and administrators must share in the decision as to what funds raised by women's auxiliaries will be used for."

Preplanning Is Necessary

Mrs. Josie M. Roberts, superintendent of Methodist Hospital, Houston, Tex., urges hospitals planning new buildings or citizens' groups organizing new hospitals to plan definite positions to be manned by volunteers.

In established hospitals, it is necessary for the administrator to sell employes on the idea of the services that can be rendered by volunteers before volunteers are put to work inside the hospital, Mrs. Roberts holds. She is of the opinion that in all cases the president of the women's auxiliary should be an ex officio member of the board of trustees.

Don't start a **ROOMING-IN** *program . . . unless you are prepared to continue it*



CLYDE F. DIDDLE
Assistant Administrator
Permanente Hospital
Oakland, Calif.

A PATIENT hospitalized today has a sense of security in knowing that his doctor has entrusted his care and treatment to highly qualified hands. He knows that new and modern diagnostic and therapy equipment is always ready and available at the doctor's request. Science is constantly going forward with great strides and the hospital patient today can rest assured that his medical care will be the best in the world.

That we are able to provide good hospital care should not cause us to relax and neglect our community obligation. We must continue to study and develop our facilities, we must give constant thought to methods of improving our patient service. We must keep abreast of scientific developments and at all times be a medical asset to the community we serve. We must remember, too, that psychological care is an essential part of good patient care.

In order that we may develop proper environment for the patient, it is necessary that we conduct studies and surveys of all phases of our institution. Surveys must be made, statistics must be gathered, patients must be contacted and their ideas noted, doctors should be questioned and their suggestions added to the study list. The nurses should be called in to express their ideas. All this information should be properly compiled and studied with the idea in mind that the mental and physical comfort of the patient is an essential part of the hospital administrator's job.

Such a study made over a period of months in our obstetrical department gave us many valuable points for improvement. New ideas were uncovered, improved methods were installed, and many small problems in the department were eliminated. Among the changes we had been considering and studying for some time was the "rooming-in" plan, where the mother and the infant are placed in the same room during postnatal care in the hospital.

Previous to February 1947 it had been our policy to place all newborns in the nursery for care, while the mother convalesced. The only contact the mother then had with her infant was at feeding time or an infrequent visit when it suited the convenience of everyone concerned. This meant at the end of the mother's hospitalization the infant was placed in her arms as she left for home and she was on her own. True, a demonstration class had furnished the mother with some ideas on the care of her infant but little experience had accompanied this demonstration and so she left for home with a stranger on her hands and little skill in caring for him.

We were not doing as good a job as we thought we should be doing. We felt the mothers could be receiving training on infant care while in the hospital that would assist them psychologically and practically. So, starting in February 1947 and without change or reconstruction in our physical set-up, we offered the rooming-in plan to our patients on a voluntary basis.

The idea that mothers and infants are happiest when they are together is not new, but the placing of the two of them together as roommates in the hospital during the first week of the infant's life is enough to stimulate discussion.

As I said, we offered this plan to our patients without reconstruction of facilities; no changes were made in any of the rooms to accommodate the rooming-in plan. Inasmuch as running water is necessary in each room used under the plan, we had to limit our use to rooms equipped with running water. To put the plan into action, it was only necessary to determine the number of cases that the doctors consid-

ered eligible for this plan and then to move the bassinets and equipment into the room with the mother.

With early ambulation an important factor in expediting the convalescence of the maternity patient, it is possible to have the newborn brought into the mother's room at the end of 48 hours. From then on, the mother can assume full care of the infant under the supervision of the nurse assigned to the service.

The fully equipped bassinet is placed in the room with the mother and her contact with the infant begins at once. She gets to know her baby earlier so that by the time she is ready to go home she has had four or five days of practical experience in caring for him under the guidance of trained people. She has the responsibility for the care of the infant, without the anxiety. The mother can rest easily under the new responsibility for she knows that if something happens that she does not understand the nurse is always there to help her.

The plan operates on a voluntary basis and the patient may decide, with the doctor's permission, of course, whether or not she wishes her baby in the room with her. In case of shortage of rooms, preference is given to the mother with her first infant or to the mother who wishes to nurse her infant.

Placing the mother and the infant together has certain advantages when we consider its practical application. One of the more important advantages is to lessen the chances of cross-infection. Also, by placing the infant with the mother, breast feeding is encouraged and doctors now feel that this is of benefit to the infant and the mother whenever it is possible. When the infant is with her, the mother has a sense of security; when she hears an infant crying somewhere outside her room, she knows it cannot be her baby as he is sleeping quietly in his bassinet beside her bed. Pediatricians generally approve of rooming-in for they have observed that many of the mother's problems at home would be eliminated if she had had the advantages of this experience and training.

The question of nursing cost under this plan is of interest to all of us. The administration of the hospital is obligated at all times to improve the quality of patient service but we all know the budget must not be allowed to increase without good reason.

Under the rooming-in plan we were sure that our nursing costs would be affected. "How much?" was the only question—and only time and experience would give us the answer. We have found that the increase in nursing costs was the only increase and that it was not out of line with our previous thinking. We had to maintain our regular nursery as before but its load was lessened by the popularity of the plan. We added one nurse for each four mothers and infants or one nurse for each mother unit. This nurse trained and assisted the mother in caring for the infant. The regular staff nurse, as previously, was responsible for the medical care of the mother. We had increased our costs slightly, but we had greatly increased our patient satisfaction. The nursing staff likes this type of care and the doctors are happier with the arrangement for each has been better satisfied with the end result.

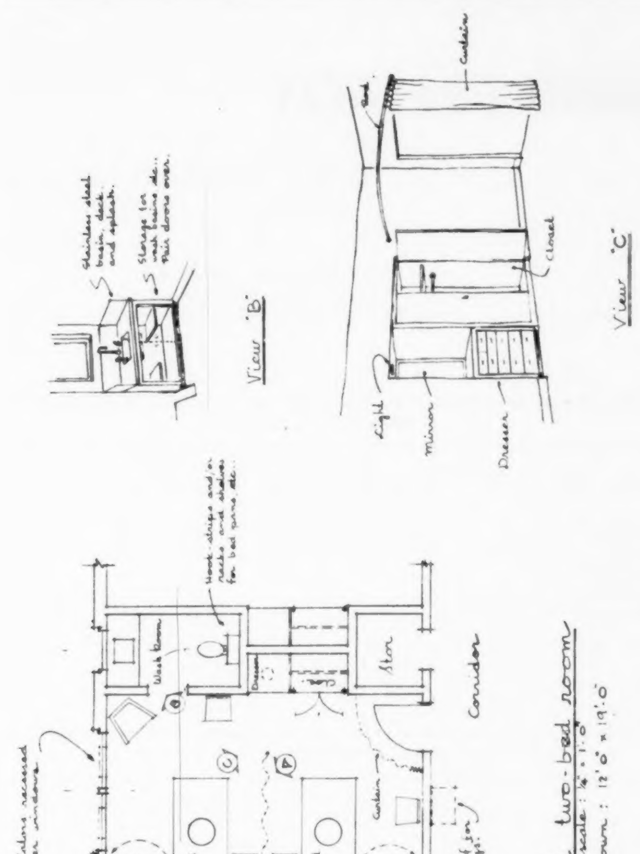
In larger rooms where space is available for four beds, partitions are set up between beds and rooming-in is done as if each cubicle were a private room. So far as our observation goes, the noise that naturally occurs with four infants in the same room does not disturb the mothers, for each one knows when her baby needs attention and she is not disturbed by the cries of the others.

We have found that certain questions are more frequently asked than others regarding this plan of placing mothers and infants together. One of the first questions asked is: What does this do to your insurance rate? The answer is: our rate has not been affected nor have we heard of anyone else having the rate changed. Then, in case the mother drops the infant, can you be sued? We have never had the problem occur nor have we heard of any other hospital with such a problem.

Then comes the most popular question: what happens when the mother wants to sleep and the infant does not agree with her plan? We have been able to solve that problem easily: provisions are made, in cases where the mother needs her rest, to move the infant out of the room and into a small room off the nursing station. This seldom occurs for the mother is generally interested in keeping the infant regardless of its noise. Then: what about visitors? If the mother is interested in many visitors and making her hospital stay a social event, the doctor may recommend that the infant be kept in the nursery. But, with rooming-in two visitors are permitted, the husband at regular visiting hours and the grandmother once or twice during the mother's stay.

In conclusion, it has been our experience over a period of three years that rooming-in is desired by the patients and approved by the doctors and hospital personnel. We have found that it encourages the mothers' sense of responsibility and the infants' sense of security. The hospital receives greater satisfaction from its efforts by allowing the mother, father and baby to get acquainted earlier and thus establish the family unit without the harassing delay encountered under the nursery system of care.

One final word of warning regarding the starting of this plan of care in your hospital—unless you are seriously planning on continuing rooming-in in your hospital, do not start it for the patients will never allow you to discontinue the advantages of such a plan.



TWO-BED UNIT

simplifies operation

RENE GORSCHALKI
Architect
Pasadena, Calif.
and
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Pasadena

THE primary objective in this unit is to simplify operations for both the nursing and the cleaning staffs, with consequent improved service and comfort for the patient. To this end, with the exception of incidental chairs, all ordinarily loose furniture and equipment have been either attached to or built into the walls, thus leaving the floor clear for easy cleaning and circulation.

A collapsible partition and sliding, top-hung curtain provide privacy when it is desired without the annoyance of loose, unstable folding screens.

The most notable innovation is the patient's bed. This unit, mounted on a hydraulic pedestal, can be readily adjusted to various heights, high for the convenience of nurses when they are administering to the patient's needs or low for patients who have a fear of the height of the usual hospital bed. The body of the bed incorporates the usual mechanism for adjusting either end of the springs for elevation.

The bed itself is so designed as to be readily detached from the pedestal and then moved about on specially designed racks or carts. This feature permits the patient to be moved to and from surgery, for example, without the necessity for transfer to a wheeled stretcher—an obvious advantage. It also permits easy solar airing for persons who might otherwise be confined to their hospital rooms.

The washroom cabinet is not an innovation. It simply provides storage for basins, pans and other utensils and is suggested only because the designers have not seen any satisfactory installations of this kind in hospital rooms. The customary electric outlets, call signals and other such facilities should be installed as usual in the hospital room.

A study of PERSONNEL PRACTICES

in New York State hospitals

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ONE significant development of the postwar period in institutional medical care is the gradual emergence of improved personnel practices for employes of nonpublic hospitals.

Because of the increasing competition from other employers for the same labor force, hospitals have had to adopt better recruiting methods, to elevate salary levels, and to improve the "fringe" benefits that employes have come to look upon as a right in all employments, public or private. Many institutions have come to realize that personnel management is an important part of the over-all management problem and have hired specialists to organize and operate personnel programs.

To ascertain the nature and extent of those personnel practices which confer "fringe" benefits on the employes of nonpublic hospitals, we conducted a survey among 31 such institutions in the fall of 1949. The data collected are virtually all from grade A hospitals distributed throughout New York State as shown in table 1.

Table 1—Data Reported by Participating Hospitals Distributed by Geographical Area

GEOGRAPHICAL AREA	NUMBER OF HOSPITALS	NUMBER OF BEDS	NUMBER OF EMPLOYEES		
			SALARIED	HOURLY	TOTAL
Capital District	4	1423	2125	200	2325
Central New York Syracuse, Utica District	10	2203	2215	651	2866
Western New York Rochester, Buffalo District	8	2960	3503	904	4407
Metropolitan New York	9	5094	7287	1067	8354
Total	31	11680	15130	2822	17952

VACATION ALLOWANCES

There is a difference in vacation benefits as between the salaried group (or staff) and employes paid by the hour. Of the 30 hospitals reporting, the salaried group on the whole enjoys more liberal treatment than do employes paid by the hour. For example, after six months' service the salaried employes receive one-week vacation allowances in 17 of the reporting hospitals while 19 of the institutions report no vacation granted to hourly rated employes with similar service periods. Reference to table 2 will disclose other differences in treatment with respect to practices among these employe groups with longer service records.

Table 2—Vacation Allowances for Groups on Salaries and Those Paid by the Hour After Various Periods of Service

	6 MONTHS		ONE YEAR		5 YEARS		15 YEARS	
	SALARIED	HOURLY	SALARIED	HOURLY	SALARIED	HOURLY	SALARIED	HOURLY
None	11	19	....	9	....	9	....	9
½ Week	1	1	....	....	....	....	....	....
1 Week	17	9	2	6	....	....	....	....
2 Weeks	1	1	28	15	26	21	21	20
3 Weeks	....	....	....	....	2	....	7	1
1 Month	....	....	....	....	2	....	2	....
Totals	30	30	30	30	30	30	30	30

Table 3—Sick Leave Allowances for Salaried Group and Those Paid by the Hour After Various Periods of Service

	6 MONTHS		ONE YEAR		TWO YEARS	
	SALARIED	HOURLY	SALARIED	HOURLY	SALARIED	HOURLY
None	2	18	1	16	1	16
½ Week	1	2	....	....	....	....
1 Week	18	10	5	6	5	5
2 Weeks	9	....	24	8	23	9
1 Month	....	....	....	....	1	....
Totals	30	30	30	30	30	30

This article expresses the opinions of the authors and may not be construed as reflecting the views of the Department of Civil Service.

In reporting vacation allowance data for their "salaried" and "hourly" workers many of the participating hospitals indicated more liberal vacation practices applicable to nursing and professional staffs.

One hospital reported a three-week allowance for nurses after six months' service while two others reported two-week and a one and one-half week vacation periods, respectively, after the same length of service. After one year of service four hospitals grant their professional people three-week vacations and two others allow one month. Following five years of service by these professional employes seven hospitals reported allowances of three weeks and five institutions permitted vacations of one month. These allowances apparently represent maximum vacation periods for these workers at this time since the data submitted for vacation allowances at the end of 15 years' service are identical with those given for the five-year service period.

SICK LEAVE ALLOWANCES

Twenty-eight of the 31 hospitals reported that formal sick leave policies exist for their employes. Two hospitals indicated that no formal policy exists and that payment for absence because of illness is discretionary with hospital officials. One hospital made no reply to this question.

The data given indicate the great disparity between the sick leave allowances for salaried workers and those for workers by the hour. Even after two years of service, the hourly worker is not paid for sick time by more than half of the employing hospitals. One-third of the employers, however, did grant one week of sick leave pay after six months' service in the hospital.

Salaried employes generally are given sick leave pay after as little as six months' service. This varies from one-half week to two weeks. After one year's service only one hospital reported no payment during illness and four-fifths of the hospitals gave a maximum of two weeks' pay.

The great variation in sick leave practices is illustrated in table 3.

HOLIDAY OBSERVANCE

Observance of the six major holidays, *i.e.* New Year's, Decoration Day, July Fourth, Labor Day, Thanksgiving and Christmas is reported by all the hospitals canvassed so far as the employes in the salaried group are concerned. However, only about half the hospitals report similar privileges for those who work on an hourly basis, When an employe works on one of the observed holidays two of the hospitals pay extra compensation, 20 permit compensatory time off, and eight hospitals use either method at the mutual convenience of the employe and the hospital.

PATTERN OF PAID HOLIDAYS

HOLIDAY OBSERVED	NO. HOSPITALS OBSERVING	
	SALARIED	HOURLY
January 1	31	16
Feb. 12	5	2
Feb. 22	13	4
May 30	31	16
July 4	31	16
Labor Day	31	16
Oct. 12	5	1
Election	4	2
Nov. 11	3	0
Thanksgiving	31	15
Christmas	31	15

The data show a clear-cut distinction between important holidays and those not generally observed in private industry. Half of the hospitals report observance of six paid holidays during the year for all their employes. One of the remaining group of hospitals pays all its employes for 10 holidays. The other 14 hospitals pay for from seven to nine holidays each year.

TIME OFF FOR PERSONAL REASONS

There is a variety of reasons included within the category of "personal reasons" in determining whether employes can get extra time off from their job. Death in the family, attention to religious duties, personal business affairs, and other lesser activties are often given as valid reasons for excusing employes with pay. As would be expected, there are no definite patterns on this practice among the hospitals.

Salaried employes in 10 of the hospitals are paid for all time off for personal reasons. Ten hospitals will pay employes for time off for personal reasons other than performance of religious duties. Two of the hospitals charge any time off for personal reasons against the vacation or sick leave account of the employe. Eight employers say that this matter of time off should be treated on an individual basis by the supervisor. When specific answers were reported with reference to time off for religious reasons three hospitals paid their employes, two others charged such time to sick leave or vacation allowances, while only four made no allowance whatsoever for such absences.

Those employes paid on an hourly basis, as would be expected, get little allowance of time off for personal reasons. One hospital pays these employes for all such time. Three permit the supervisors to treat the matter on an individual basis, presumably the criteria being the seniority and good record of the employe. Two hospitals pay these employes for time off for religious observance. In all other cases the employe either is not paid or is charged vacation or sick leave time whenever he is absent for personal reasons.

CARE OF TUBERCULOUS PATIENTS

Only eight of the 31 general hospitals surveyed treat patients for tuberculosis in their institutions. Of these eight, two report the payment of a differential to their employes. One of these hospitals pays $5 a month extra to nurses, and the other reports extra compensation of $20 per month for registered nurses and $10 a month for all other personnel in contact with these patients. Twenty-two hospitals report treatment of tuberculous patients for conditions other than tuberculosis. Only two report the payment of premium compensation for the hazard of caring for these patients. In each instance special nurses assigned to TB duty are paid daily premiums of $1 and $2, respectively.

OVERTIME COMPENSATION

Information reported by hospitals regarding their overtime compensation practices displays a pattern very different from the one encountered in the industrial and commercial fields. The basic work week for hospital employes varies from job to job and from institution to institution between a minimum of 40 hours and a maximum of 48 hours.

Overtime work beyond the basic work week is compensated for in one of three ways. Eight hospitals pay at a time and one-half rate. Ten hospitals compensate their employes at their straight time rate. Four hospitals give time off in lieu of overtime pay. The remaining nine hospitals use some combination of the straight time and time off methods. One hospital reported payment of double time for work performed on an employe's normal day off.

SIR WILLIAM OSLER

By OTHO F. BALL, M.D.
President, The Modern Hospital Publishing Company, Inc.

A LITTLE girl, soon to die, awaited her daily visitor. There came a tap low down on her door, ushering in a crouching gnome who in high pitched voice begged a drop of tea from his fairy godmother. Little maid and man talked of flowers and birds and dolls, then mysteriously he slipped away, still crouched low on his heels and the little girl laughed happily.[1]

The man who so loved little ones and roamed with them through the Never-Never Land was the greatest physician the modern world has ever known, Sir William Osler. A man so filled with love for his fellowman, he inspired an admiration that was almost worship. Although he won the most coveted honors attainable in the medical world, he proved that modesty and a simplicity of life are not incompatible with a position of the highest possible eminence.[2] A classicist, a learned historian, a bibliophile, a brilliant student and teacher of medicine, he remained a sympathetic loving friend, a wise counselor to all who sought his aid.[3] Unostentatiously, he was ever a leader, unresented and adored.

Son of an English minister who came to Canada as a missionary, William Osler was born in Tecumseh, Upper Canada, on July 12, 1849. He was not a brilliant young student, for he was full of harmless, annoying pranks. His gay good humor and his love for little jokes ever remained with him. They did no real harm. A typical joke was warning his wife that the important guest coming to dinner was hard of hearing and whispering to the guest that his wife was very deaf, then sitting back and listening to them shouting at one another. It is said that in the last year of his life, at 70, while vacationing, he did somersaults and turned cartwheels on the sand. Oft he smiled in the face of sadness. Drawing the cover about the dead as gently as for a sleeping child, he would turn away—perhaps whistling. To a physician who did not know him and who once spoke almost in rebuke of the seeming frivolity in his manner, Dr. Osler's answer was, "If I laugh at any living thing, 'tis that I may not weep."

His three ideals, expressed at the farewell dinner given when he left America, were, first, to do the day's work without bothering about tomorrow, doing it to the best of his ability and letting the future take care of itself. Second, to follow the Golden Rule as far as in him lay, and, third, to cultivate such a measure of equanimity as would enable him to bear success with humility, the affection of his friends without pride, and to be ready when came the day of sorrow and grief to meet it with the courage befitting a man.[4]

A newspaper cartoon representing Osler as the saint of Johns Hopkins.

At 18 he entered Trinity College, Toronto, where under the influence of his beloved teacher, Dr. James Bovell, he came to love the great books and to enjoy the wonders of the microscope. Dedicated to the practice of medicine, he was graduated from McGill University in 1872 and for two years studied in the famous clinics of London, Berlin and Vienna. On his return, then only 25 years old, he became lecturer, then professor of the Institutes of Medicine at McGill. He threw himself into his work with the energy and enthusiasm that distinguished him later as a great teacher. As pathologist of the autopsy room he began his career as a morbid anatomist and later as a distinguished clinician. Later in his discussion and diagnosis of a case before his eager students he was always able to depict similar cases from the storehouse of his memory.[1]

In 1884 he was appointed professor of clinical medicine at the University of Pennsylvania. Here, as at McGill, his striking personality and vivid expositions thrilled his students, filling them with an intense desire to copy the Master. At the Dead House at Blockley they absorbed pathology as revealed before their eyes.

Five years later Osler became professor of medicine at Johns Hopkins University[5] and here at last came the opportunity of which he had dreamed: to set up a clinic after the Continental pattern. During the six years between the time of the opening of the hospital and the completion of the university buildings and entrance of the medical students, Osler was able to perfect his organization of wards, outpatient department, staff, records and library. The staff consisted of young full-time doctors living in the hospital and caring

Sir William Osler in 1891 writing his textbook, "The Practice of Medicine."

for the patients and older practitioners giving only part time to the hospital.

Osler's first concern, Barker states, was for the welfare of the patient, the next for the education of the students, and, finally, for advancing knowledge of internal medicine. He stressed the need for careful history taking, for establishing scientific laboratory methods in chemistry, physics and biology, for study of disease, and for training the students in careful collection of clinical and laboratory data, each student taking individual part in diagnosis and treatment of the diseases of the patients. He succeeded in arousing such an interest in his students that the strenuous work under their indefatigable leader became a game in which each one strove to prove his worth.[2] So successfully did Osler set up his clinical methods that Johns Hopkins Hospital has continued to serve as a pattern and ideal for many other institutions.

Osler's noted textbook, "The Practice of Medicine," first published in 1892, was immensely popular, went through many editions, and was a basic textbook in many countries. Up to that time his work had been confined to the teaching and practicing of clinical medicine. Except for his "Aequanimitas," his literary contributions were on that subject. From 1892 to 1919 he published a series of brilliant literary works, humanistic and biographical. In all, he published 730 titles with a brilliancy of style and a whimsical humor.[6]

At 42 he married Grace Revere Gross, widow of the noted Dr. Samuel Gross and a great granddaughter of Paul Revere. When their son was born in 1895, they named him Revere. He was a wonderful lad and their great joy. Very early, like his father, he began a collection of the classics.

Then in 1905 Osler was called to Oxford to become regius professor of medicine, the first of these noted professors to be well grounded in medicine. His home became a mecca for visitors from America and other lands, and almost a home for Rhodes scholars. As in America, Osler threw himself into the work of the school and of the community. He began, too, his Bibliotheca Osleriana, a catalog of his famous collection of medical history which he planned to give some day to McGill University and where it now reposes, a new mecca for medical students and physicians. In 1911 King George V created him a baronet. Honors were heaped upon him in America and in other countries.

The greatest teacher of medicine since Hippocrates, Galen and Boerhaave,[3] greater than any since, who brought healing and happiness to so many, who had placed a comforting arm about the shoulders of so many who sorrowed, lost his only son, his beloved Revere, at Ypres in 1917. Sir William wept desperately at first, then true to his code, threw himself tirelessly into the vast war work at home. New honors fell upon him. Perhaps his presidency of the famous British Classical Association brought him the greatest joy. To his son's collection of the classics he added his own non-medical collection and sent them as a memorial to Johns Hopkins University.

Osler's seventieth birthday in 1919 was celebrated by the great of the earth and by his old students and friends. At the end of the same year he died, of pneumonia. His great work continued to live after him, for as he revolutionized the teaching of medicine at Hopkins, the clinics since have followed the pattern. His textbook was used across the globe and the men he taught became in their turn teachers, noted physicians or eminent in research.

"His great talents at all times and in all circumstances were devoted to mankind and to the relief of the sick and suffering. His humility, devotion to duty and the sympathetic spell with which he attracted friends to his side gained for him the title worn by his forerunner, St. Luke, of the "Beloved Physician."[7]

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Small Hospital Forum

RATES AND CHARGES *established by small hospitals are the concern of the whole community*

CLIFFORD G. SAWYER
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THE basic facts and reasoning used in setting general hospital rates are not always as apparent as are the mechanisms used in arriving at these rates. This is generally true of voluntary community hospitals, including those in rural areas. The community hospital in a rural area tends to establish rates that will adequately meet all operating expenses, that will compare favorably with rates of its neighboring institutions, and that will bear some relation to the cost of giving a particular service. The small community hospital in establishing rates in this manner is using the proprietary hospital approach to its financing problems. This is understandable as many of these institutions had their beginnings in a proprietary hospital set up in a converted residence not too many years past.

HAS ITS LIMITATIONS

The small community hospital is inclined to approach the problem of setting rates and charges in the same manner as the manufacturer who first surveys the market to determine sales volume and competing prices, then determines the cost to produce the product, and finally sets his price at a point which will assure the sale of the product at a profit to himself. This is good business practice but has its limitations for a community service institution. The trustees and administrator of a community hospital sometimes fail to realize that their patients are not the only individuals who benefit from the hospital's existence. Their institution performs a stand-by service for every individual within the hospital area. This stand-by service should be evaluated in dollars and cents and a suitable charge should be made, to be collected in some manner from the community at large.

It is a basic fact that a general hospital, properly conceived and operated, serves its community by merely being open, available and ready to serve even though it may not admit or care for a single patient. This stand-by service is worth something to every community that receives it. On an average it will amount to at least 20 per cent of a small community hospital's operating expenses. This figure can be demonstrated to the trustees of any community hospital by a simple analysis of operating expenses. It can also be demonstrated to the community, for it is a readily understood concept.

Other community services, whether they be the fire department or the telephone company, are financed in whole or in part on this principle. Most people are aware of the fact that their taxes support the fire department whether they have a fire or not and that the telephone company makes a service charge even though they never lift the receiver. It is an economic fact of life that one must pay for having a service available, whether it is used or not.

MUST AGREE ON STAND-BY COSTS

It is therefore apparent that the stand-by or readiness-to-serve costs must be agreed on and provided for by the community at large before patient rates to cover service costs are computed. This requires the division of the hospital's operating expenses into readiness-to-serve costs and service costs. This is a relatively simple operation. The bookkeeper merely totals the salaries and food costs for the minimum number of employes needed to keep the hospital in condition to receive and care for its first patient, and to this is added the cost of keeping the hospital heated, lighted, insured, repaired and supplied with telephone service. This is the readiness-to-serve cost.

Now some may quarrel as to its detail, such as the exclusion of depreciation, but none can refute its existence or importance. Service costs are then the remainder of the hospital's operating expenses, and it is these costs upon which rates for patient care should be based if we intend to be wholly fair with that small part of the community which is hospitalized each year.

SHOULD BE SEPARATED

It is also recommended that related hospital activities, such as an outpatient department or a school of nursing, have their direct costs separated and met by the community as a whole. The cost of indigent care or the cost of education is primarily a community responsibility and, as such, should not be reflected in the rates individual patients pay for being hospitalized.

If the community will meet its equitable portion of the hospital's operating expenses from tax funds or community chest endeavor, the hospital patients as a group will then only be required to meet the cost of services and supplies used or consumed directly by them while in the hospital. It should be noted that these service costs cease upon discharge of the patient. This is the primary characteristic of service costs, and it enables them to be used for establishing rates to patients with no consideration of the hospital's probable occupancy. These rates, because they are based on

service costs, have to cover only services and supplies used or consumed if and when a patient is admitted. The services and supplies used, in keeping the hospital in a position to serve, are provided by the community at large.

The small community hospital in establishing the rates to be charged individual patients should first assure itself that these rates will in total meet its service costs. In addition, the rates adopted should assure a high quality of service sufficiently diversified to meet the needs of the community as a whole. Last, these rates should assure the widest possible use of both the hospital's facilities and its personnel.

The average individual in a rural community uses the hospital as a necessity rather than as a convenience. The rates adopted should encourage the use of the hospital by these people. They should play down the time-honored practice of overcharging the wealthy to help pay for the poor. Although the sick man may be wealthy, it is still not equitable to burden him with the responsibilities the community as a whole should carry.

IRRITATED BY "PIECEWORK BASIS"

The average patient admitted to a small community hospital looks upon his stay there as a single experience. Most of the diagnostic tests and therapeutic treatments he receives are not of his choosing. In fact, he is not even aware of receiving some and is surprised when they appear on his bill. As a result, he is irritated by a hospital bill that itemizes and charges on the piecework basis. Such a bill is unpredictable in amount and may be the cause of considerable anxiety. The patient would prefer to be billed in a manner that would remove much of the uncertainty as to the total amount of his bill upon discharge. For these reasons and others, the small community hospital should consider the use of inclusive rates.

The adoption of inclusive rates enables a hospital to charge for its service primarily in terms of the length of stay for each patient. The variables found in most inclusive rate plans generally confine themselves to type of accommodation and type of case, both known at the time of admission. This method of billing introduces an element of certainty, which has tremendous appeal to any patient and is in itself good medicine. The desire for certainty, it should be noted, sells health and hospital insurance.

A patient no doubt benefits clinically under the inclusive rate plan, for it encourages the use of those special services which are most essential to prompt diagnosis and adequate treatment. The doctor is able to give the best service he knows how to ask for, with no resistance from a financially embarrassed patient. The result should be shortened hospital stays, greater turnover of patients, and more efficient use of expensive hospital facilities. This method of charging emphasizes the fact that a general hospital is primarily a diagnostic and treatment center. Unfortunately, the current trend of loading higher rates on an increasing number of special services tends to discourage their use and emphasizes the general hospital as a place for bed rest.

The administrators and trustees of small community hospitals are often hesitant about adopting a system of inclusive rates. They doubt its ability to bring in the needed revenue and they believe that the day-rate-plus-extras system is much fairer to the patient, as he pays the cost of services actually received. On the first point, it can be said that mathematically it is possible to develop inclusive rates which will return any desired amount of revenue. Furthermore, once the pattern has been established, it is easily adjusted to meet changes in operating expenses. It should also be pointed out that the financial planning to cover new items of service is simplified. Under the inclusive rate system these can be adopted purely from the point of view of total efficiency and total patient income. Under the day-rate-plus-extras system new items of service tend to be tied to new sources of revenue, which may retard the well rounded development of a hospital.

Historically, hospital services were first covered by a single day or weekly rate for which the patient received complete care. Then, as scientific procedures in the clinical laboratory and in x-ray were introduced into hospitals, it became necessary to raise funds to cover the costs of these services. Since many of the new services were used by only a few members of the medical staff, it was decided to make a special charge to the patients receiving them. The charges then made had no direct relationship to cost.

The number of these special services has today increased and many of them have become routine. However, they are still charged for on a piecework basis. These charges have only a limited relationship to cost, often being based on those made by neighboring hospitals. Charges made for room, board and nursing are particularly hard to relate to cost. The reason for this is obvious when one considers the wide fluctuation from case to case in costly nursing service. This daily room charge is in itself an inclusive rate and pretty well explodes the theory that a patient's bill under the day-rate-plus-extras system is based on the cost of services received.

PATIENTS DON'T CARRY JOB TICKET

Cost accounting as used in business and industry has no place in hospital administration. Patients are not in the same class as damaged automobiles, which, when placed in the repair shop, carry a job ticket upon which is listed the cost of the new parts plus the cost of labor as recorded by a time clock. On the other hand, cost analysis, in which all of a hospital's operating expenses are allocated, by rule of thumb, to revenue producing services, has been found of some value. Such a study gives an approximate relationship of expense to revenue for any given revenue producing department. However, its value is limited in the determination of charges for units of service, such as a particular diagnostic test, and it gives practically no assistance in determining individual charges for nursing and dietary service—two items that account for at least half of the small community hospital's operating expenses.

It is perhaps just as well that cost accounting or cost analysis cannot be used too effectively in determining the rate for a particular unit of hospital service. Many of the diagnostic tests performed in hospitals benefit not only the patients but the community at large. Chest x-ray and luetic tests are public health measures and, as such, should carry a rate that will encourage their use. The small community hospital is a public health institution of value to everyone in the community. Its strength and its weakness are the concern of every individual in the hospital's service area. The rates it establishes are not just the concern of the hospital trustees and the individual patient; they concern the whole community and should be established on the basis of how they will best promote the public health.

About People

Administrators

C. G. Salsbury

Dr. Clarence G. Salsbury has retired as superintendent of Ganado Mission and medical director of Sage Memorial Hospital, Ganado, Ariz. Dr. Salsbury, **Dr. Charles W. Sechrist** of Flagstaff and **J. O. Sexson** of Good Samaritan Hospital, Phoenix, were responsible for the formation of the Arizona Hospital Association some years ago of which Dr. Salsbury has been president. He has also served as president of the Association of Western Hospitals.

Roy Wilmesmeier has resigned as administrator of Southern Pacific Hospital, Houston, Tex., to take over the duties of director of hospital relations with the Texas Blue Cross. **Thomas B. Sellers,** who received his master's degree in hospital administration from Northwestern University and who has been serving as assistant director of Hermann Hospital, Houston, Tex., has been named to succeed Mr. Wilmesmeier at Southern Pacific.

Kenneth S. Craft, manager of the Veterans Administration district office at Boston, has been named manager of the Veterans Administration regional office at Nashville, Tenn. He succeeds **J. M. Nixon,** who was retired recently.

Ralph R. Hobart has been appointed administrator of the Coffeyville Memorial Hospital, Coffeyville, Kan., to succeed **Alma I. Schiek, R.N.** Mr. Hobart had been administrator of Ransom Memorial Hospital, Ottawa, Kan., for the last year. Prior to that, he was assistant administrator at Iowa Methodist Hospital, Des Moines. He assumed his new duties at the Coffeyville Memorial Hospital on November 1.

Edward S. Van Wagenen has replaced **Dwight P. Hansen** as administrator of Lakeside Methodist Hospital, Rice Lake, Wis. Mr. Hansen is now business manager of the Lakeland Medical Center at Wilmar, Wis.

Robert M. Schnitzer, formerly assistant director of Orange Memorial Hospital, Orange, N.J., has succeeded **Charles Lee** as director of the Lutheran Memorial Hospital, Newark, N.J. Mr. Lee recently retired after completing 31 years in the field of hospital administration.

Mabel W. Binner, administrator of Children's Memorial Hospital, Chicago, for 21 years, has announced her plans to retire. No successor has been appointed. Miss Binner became director of the outpatient and social service departments of Children's Memorial in 1924. After five years in that position she took a course in hospital administration at Columbia University, and was called back to the hospital to become administrator in 1929. Miss Binner has been active in hospital organization work, serving on committees of the American Hospital Association, the Illinois Hospital Association and the Chicago Hospital Council. She is a charter fellow of the American College of Hospital Administrators.

Harold J. Roig has been named executive trustee of the Lenox Hill Hospital, New York City, **William H. Zinsser,** hospital president, announced. The office is newly created, Mr. Zinsser said. Mr. Roig will be concerned with supervision of hospital activities and economies in business operations.

C. Minot Doyle has been named assistant to the president of Memorial Center for Cancer and Allied Diseases, New York City, **Laurance S. Rockefeller,** president, has announced.

Dr. Nathan Beckenstein has been named director of Syracuse Psychopathic Hospital, Syracuse, N.Y. He assumed his new duties on October 15. In his capacity as director of the hospital, Dr. Beckenstein will be a member of the staff of Syracuse University.

Frank Scott, a graduate of the Columbia University course in hospital administration, has been appointed assistant administrator of Norfolk Community Hospital, Norfolk, Va. Until his new appointment, Mr. Scott was associated with Freedman's Hospital, Washington, D.C.

Rhoeine A. Glascock has been named administrator of Gnaden Huetten Hospital, Lehighton, Pa. Miss Glascock, who earned a bachelor of science degree, majoring in hospital administration, at Northwestern University, has been granted a six months' leave of absence from Bloomsburg Hospital, Bloomsburg, Pa., with permission to serve as part-time administrator at both hospitals. She was appointed to the Bloomsburg post in 1948.

Oscar Schneidenbach, who has been administrator of Berwick Hospital, Berwick, Pa., for a little more than a year, resigned in August.

Dr. Eugene D. Rosenfeld, assistant director of Montefiore Hospital, New York City, has been appointed executive director of the new Long Island Jewish Hospital, New York City. He will assume his duties there about January 1.

W. L. Agress

William L. Agress has been appointed assistant director of Mount Sinai Hospital, New York City. Mr. Agress, formerly an official of the Brooklyn Tuberculosis and Health Association and of the New York State Department of Health, recently completed at Mount Sinai a year's study in hospital administration under the S. S. Goldwater fellowship.

Dr. John J. Tyson has been named manager of the Veterans Administration hospital soon to open in Omaha, Neb. Dr. Tyson had been chief medical officer at the V.A. center in Des Moines, Iowa.

Henry L. Goodloe has resigned as administrator, Passaic General Hospital, Passaic, N.J.

Arny H. Hammann has been appointed manager of the Veterans Administration regional office in Little Rock, Ark., to replace **James A. Winn,** who is retiring from government service. Mr. Hammann has been with V.A. and its predecessor agencies for 29 years.

(*Continued on Page* 170.)


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Who Is Responsible

for medical and hospital care?

HARRY BECKER
Director
Social Security Department
U.A.W.-C.I.O.
Detroit

MEDICAL and hospital services cannot be isolated from the forces that make for change. Nor should they be. To the extent that we can bring about progress in other fields, we can give direction to the progress in medical and hospital services. If the leaders in the medical and other health professions adapt wisely to the changes in the social and economic environment, they can preserve their fundamental freedoms: intellectual freedom and essential self-government concerning their standards and disciplines.

However, if wise adaptation is to take place, we must first recognize that the pattern of medical and hospital services that was appropriate for the horse and buggy doctor is not suitable today. Once we accept this fact, we can abandon the fear of all change. And we can analyze the reasons that lead us to discuss the question of whether or not medical and hospital services are the responsibility of the state or the individual. We can then adjust our medical and hospital pattern with a minimum dislocation and with maximum advantage to professional standards.

NOT "EITHER-OR" CHOICE

The question, of course, is not whether the responsibility for medical and hospital services rests with the state or the individual. This question makes the problem seem much too simple and suggests much too easy an answer. For if we face the issues squarely and honestly we can see it is not an either-or choice we have to make. The responsibility for medical and hospital care does not rest primarily with either the state or the individual alone.

To say that medical and hospital care is the sole responsibility of the state is to accept an idea of the state that is incompatible with our concept of a free and democratic society. To say that it is the sole or primary responsibility of the individual is, on the other hand, absurd. Responsibility for medical and hospital care belongs not to the government or to the individual acting alone but must be shared between the professional personnel equipped to provide medical services and the consumers who need these services. But in achieving the proper relationship, the health professions and the consumers may have to utilize the instrument of government, and properly so, to accomplish objectives that cannot otherwise be attained. In fact, they now use government to help in the construction of hospitals, to further medical research, and to provide services to veterans, for example.

The areas of responsibility that belong to the professions, the consumers and the government are defined in part by the forces for change in the existing patterns of medical and hospital services.

The need for change emerges primarily because our concept of the standards of medical and hospital service is broadening. The medical profession wants to provide higher standards of service for the individual as well as for the total community. And the consumer wants higher standards of medical service for himself and for members of the community in which he lives.

The physician's office or the hospital laboratory a quarter century ago was as different in appearance and equipment from the modern clinic and diagnostic facilities as the grocery store of 25 years ago is different from the supermarket of today. Medical services have changed as markedly in the last quarter century as have the processing and sale of foods. Medicine, too, requires modern methods of service and distribution.

Yet fresh frozen fruits and vegetables in midwinter, no matter how appealing, are obviously nowhere near as important as high quality medical services, which are now available to far too few. If a new and expensive drug or a costly diagnostic procedure is needed by their sick child, the parents want it desperately. Even when all members of a family are well, they are aware that they may need medical care at any time and take a deep interest in each new discovery in the medical laboratory. So consumer demand for improved medical and hospital services continues to grow. And it aggravates the problem of how to distribute these services to the people and how to meet their cost.

WE SELECT ALTERNATIVES

When we as individuals are priced out of the market for nonessential foods and other goods and services, we select alternatives. If we cannot afford the price of a new car we buy a used one. If we cannot afford the price of a new and modern house, we buy an older and cheaper one. The used car provides transportation to work and the old house provides shelter even though they may not represent our first or even our second choice. But when we are ill there can be only one choice. We do not want to choose less than the best nor do we want to go without medical care because the cost is too high. Nor do we want anyone else to be without the best medical service because of expense.

We cannot choose when to be ill nor can we choose our illness by its price.

When major illness strikes, the chances are slight that the wage earner can meet the total costs out of current earnings — if he seeks the best medical care. Nor can he save enough to meet the modern costs of illness, since he must bear the double burden: loss of wages during his sickness, and an unpredictable medical expense. Only those in the upper income brackets are able to make such savings. And expensive illness is only one of the contingencies for which we, as a responsible people, must make provision. Most families cannot put aside money to meet this cost as well as to provide for periods of unemployment or underemployment, old

From a paper presented before the Ohio Hospital Association, Columbus, 1950.

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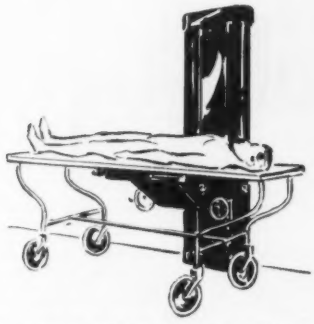

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age, or premature death of the wage earner.

How, then, are we going to meet the contingency of illness? The problem is much larger and much more complicated than that suggested by the solution that workers save for the time when they or their families will be sick. Neither does the solution lie in the proposal that all medical and hospital services be paid for from government tax funds.

The problem of making available a high and uniform quality of medical and hospital service for all people regardless of where they live or how much they earn or save is twofold: it is economic (or financial) and it is organizational. The economic problem is how shall the costs of medical and hospital services be met. The organizational problem is even more complex than the economic one and I should like to discuss it first.

STILL MUST IMPROVE QUALITY

Even if all the funds needed for universally available medical and hospital services were appropriated today from general revenues, our basic job of improvement of the quality of care would still be ahead of us. Organization is required to distribute medical and hospital services throughout the country, in both urban and rural areas, so that a uniformly high level of quality is assured. Organization is also necessary in the coordination of facilities to achieve a functional relationship between the smaller clinics and hospitals and the larger, better equipped institutions. Under the heading of organization there is also the problem of how to bring all physicians into some clinic or hospital relationship so that individual practitioners will not be isolated and without opportunity to keep fully informed on technical medical developments. And there is the problem of how to encourage and develop group practice among physicians.

An improved organization pattern for the distribution of medical care does not just happen. It must be developed by people who know how to organize and who have the time to do the interpretative and administrative jobs.

But to cope with the problem of organization of medical and hospital services, we must find ways to underwrite the costs involved. It takes money to provide additional hospital beds and to construct clinics for group medical practice. Continued training for physicians in practice requires teaching facilities. To make diagnostic procedures generally available requires laboratory and x-ray equipment and personnel that knows how to use it. Comprehensive medical care requires a team of physicians and auxiliary personnel, including public health nurses and medical social workers, and facilities for them. All of these things require money. So we reach the economic problem.

Financing medical and hospital services is a means to an end, and that end is the development and promotion of universally available medical and hospital services of the highest quality. But there is no easy answer to the question of where is the money coming from.

It is true that our national income is limited by what we produce. We cannot build hospitals, extend our medical research and training activities, and pay physicians a living wage without production of goods and services of sufficient value to meet our medical and hospital needs as well as our other needs. Our national income is large enough for this purpose. But, as I have already pointed out, the individual worker cannot save enough from his income to meet the costs of medical care, pensions and the purchase of a home.

The worker must buy his house through payments made over a period of years. He must pay for the education of his children through taxes paid over a lifetime. Pensions are earned and financed through prepayments made throughout his work life. Many expenditures are made on a prepayment or distributed-payment basis and not out of individual savings. Few of us could buy a house from savings or pay for the education of our children from savings. How many could save the $16,000 needed at age 65 to assure an income of $100 per month for life? We use the insurance principle to spread these costs over a large number of people and over a period of time.

The answer to financing personal health services is also prepayment or payment distributed over a period of time. This can be accomplished in part for the middle and upper income groups, while they are gainfully employed, through such organizations as Blue Cross and Blue Shield. The unemployed and the underemployed, those making less than a living wage, the aged, and the infirm cannot make monthly payments to Blue Cross or Blue Shield. Our medical and hospital services will not be adequately financed and all of our people will not receive the kind of care our medical schools teach unless and until every patient is a paying patient for the doctor and the hospital.

The job ahead is to find an organized and coordinated method for prepayment so that every person is protected against the economic cost of medical and hospital care.

Today we have not fully accomplished this objective. Blue Cross has gone a long way in helping the wage earner while employed and Blue Shield has made a start in the direction that Blue Cross has gone. Labor unions such as U.A.W.-C.I.O. have a stopgap or partial answer by asking the employer to set aside, as an economic increment for the worker as part of wages, money for prepayment of hospital and medical care. This was one of the major issues in the recent Chrysler strike.

CANNOT DO WHOLE JOB

I say this is a stopgap and partial answer because our collective bargaining programs cannot do the whole job for all of the people. Unions cannot fail to recognize their responsibility to the total community. We cannot make gains for labor that we do not share with the community. Therefore, we cannot be satisfied until we have accomplished for all of the people what we seek for our membership.

In the next year or two the United States is going to evolve a system, a coordinated system, that will meet the problem of financing personal health services. This system will undoubtedly be based on individual responsibility because that is consistent with the kind of democratic life we are all working to maintain and strengthen. Democracy implies maturity and in a mature society we are equally concerned with all members of society. Therefore, we will use the instrument of our government — on federal, state and local levels — to assist us in doing what we cannot accomplish as individuals acting alone or acting together on a nongovernmental basis. Government will by necessity have to fill the gaps that exist in our present system of financing personal health services. Government will have to assist in coordination of methods of prepayment.

Government must assist in financ-

ing the facilities needed to supply hospital beds to all communities. Areas with low per capita income will need government help to bring their level of health services up to the standard available in our richer states. Government funds will be used increasingly for research. They will be used for special disease categories and for preventive services. Without the help of government services we would not have had the facilities necessary to minimize the economic and social effects of tuberculosis and venereal disease. The government will aid medical schools in construction and in support of research and educational programs. Private philanthrophy does not now produce the revenues or the organized approach necessary for modern medical and hospital care.

Our care of the mentally ill is still a national disgrace. This problem will have to be met in large part from federal funds because the states do not have the sources of taxation necessary to bring their mental hospitals and public health services up to standard. We have hardly made a dent on the mental illness problem.

This governmental participation must not blind us to the great importance of individual responsibility in this evolving system. In this area it will be vital that the medical professions and the consumers plan together for the provision of medical care.

In the meanwhile, we must look at the existing mechanisms for providing protection against the economic hazards of illness.

BLUE CROSS OFFERS MORE

Blue Cross has had a phenomenal growth. More and more groups are being covered through collective bargaining. Commercial insurance companies, Blue Cross and other types of prepayment plans are the only machinery for insurance protection against the cost of hospitalization. With a few exceptions, the Blue Cross plans offer more dollar for dollar and benefit for benefit than do the commercial insurance carriers. Blue Cross, however, is still spotty in the level of benefits provided and still has to work out a satisfactory national standard of protection. In some states there is need for coordination of Blue Cross on a statewide basis so there can be a uniform level of protection.

From the standpoint of labor, Blue Cross should provide as nearly a nationwide uniform benefit as circumstances permit. This benefit should represent full payment of all items on the hospital bill related to the medical care of the patient and should have a minimum of restrictions. On group admissions, Blue Cross, we feel, should follow the pattern of the insurance companies and remove all restrictions as to preexisting conditions. We believe, too, that Blue Cross must take leadership in keeping hospital costs within reasonable limits by developing methods of paying hospitals that assure proper allocation of hospital costs to patient care. Research and training should be met from funds other than patient charges.

Labor feels that Blue Cross is an organization clothed with a public interest, because of the nature of the service that it performs and because of the large population it covers. Therefore, it should include on its boards of trustees representatives of labor and the general public. Only when representatives of the consumers sit down together with members of the hospital profession are we going to achieve the joint planning of Blue Cross programs that will provide optimum service to the patient and fair compensation to the hospital.

Labor feels even more strongly about the reforms that Blue Shield plans must undertake. The Blue Shield plans are far from making the contribution that they might make toward improving the quality of care and removing the economic barriers. The majority of Blue Shield plans have income ceilings that are lower than the average income of most regularly employed workers today. These workers have no assurance when they go to the hospital that the allowances under Blue Shield will cover the cost of their medical care. In fact, studies made by the U.A.W.-C.I.O. indicate that our workers have to pay, on the average, about 40 per cent of the surgical fee in addition to paying their monthly premiums. For major surgical procedures, Blue Shield allowances provide an even smaller proportion of the physicians' charges. Thus, workers who believe that they are insured against surgical expense find that they must make substantial additional payments that they are not prepared to meet.

The reaction of our members to this situation is illustrated by a letter I received recently: "I know that in every case we have in our shop the workers have been overcharged, and they are getting fed up. . . ." And this is only one from a constant stream of protests.

If Blue Shield is to receive labor's support as the carrier of choice for programs established under collective bargaining, the income ceilings should be moved high enough to guarantee all workers payment of the total medical bill. In addition to this, limited coverage and failure to encourage group practice and other measures for the improvement of the quality of care constitute the most serious deficiencies of Blue Shield plans.

Blue Shield can find ways to give this service at a reasonable cost. This can be done because it is really not necessary to increase fee schedules to guarantee a respectable income to physicians. When doctors are paid an agreed allowance for every service, they will have a larger income than when they charge higher fees and receive far fewer payments. This is true when there is partial prepayment as well as no prepayment.

MUST RECOGNIZE RESPONSIBILITY

Blue Shield plans must also keep their administrative expense down. They must recognize their responsibility to the public and must elect to their boards of trustees representatives of their membership. Physicians and the consumers must sit down together here, as in Blue Cross, to plan really effective programs.

The U.A.W.-C.I.O. is currently withholding its endorsement of Blue Shield until the income ceilings are increased to include all workers in collective bargaining contracts and until all in-hospital medical care is covered. We are, also, asking the Blue Shield plans to broaden the representatives on their boards of trustees.

Let me sum up our answer to the question of state or individual responsibility in the light of these facts. The various arrangements we have described represent the efforts of the American people to find ways to provide for their medical and hospital care. Traditionally our citizens first try the individual and the group approach to solve their problems. But when such efforts have failed they have used the instrument of government. Education is an example of this. If the medical profession fails to work with the people in the solution of their mutual problems, the people — who, after all, are the government — will take the next step.

as the lawyer sees

Hospital-Specialist Relationships

HOWARD BURRELL
Attorney
Association of California Hospitals
San Francisco

ONE of the most aggravating problems facing hospitals is that of properly maintaining their relationships with radiologists, pathologists, anesthesiologists and other specialists.

Realistically approached, the problem is one of economics, with a window dressing of professional ethics. It flows from the impact of hospital economics against medical economics and unfortunately the patient too often finds himself in the middle of the conflict.

MUST PRODUCE REVENUE

It is an acknowledged fact that for the modern hospital to survive, its receipts from its specialty departments must substantially exceed its expenditures made in the operation thereof. Without such a condition the hospital could not operate many necessary non-revenue producing departments and would fail miserably in the performance of its obligations to the community. However, it is also a recognized fact that such a condition must be maintained without any exploitation of its specialists and without violation of professional ethics or diminution of professional standards. How to attain such a utopian status as has just been described is the problem, and all attempts at its solution are fraught with trials and tribulations, most of which are based on the frailties of human nature.

Many of the arguments and statements on this subject have been entirely unrealistic and have been developed without recognition of the true merits of the problem. It is certainly time that both the supporters and the opponents of the different facets of this problem should take a constructive approach to its solution and look at it from the point of view of the patient. Should it appear that such a satisfactory solution is impossible within the framework of existing laws then the medical profession should join with the hospitals in seeing that the laws are made adequate to permit of such a solution. The fundamental obligations of hospitals and of the medical profession must be to the patient and any other approach to the problem will subject both groups to public censure.

What, then, are the basic elements of this problem? One element is that a hospital patient does not select his own radiologist, pathologist and other specialists, but receives their services as a matter of course and as a necessary part of his hospitalization. It would be utterly impossible for the ordinary hospital to maintain a group of such specialists from which the patient could make his choice, and therefore there can be no freedom of choice on the part of the patient.

As a matter of practice the patient relies on his physician or surgeon to select the hospital and assumes that he will not be sent to a hospital where the specialty services are substandard. It is most unusual if the patient has any personal contact with these specialists during his entire stay in the hospital. At most, the patient may have a brief contact with a technician or a specially trained nurse who handles the mechanical part of the testing or treatment. In a large percentage of the cases a specialist, except for general supervision of and responsibility for his department, does not in any way participate in the services performed for the patient. Even though the specialists fail to have the same type of confidential relationship or receive the same degree of personal trust that a patient feels toward his attending physician or surgeon, there is no doubt that the specialists make a great contribution to the care of hospital patients.

Another part of the problem is that the patient regards the services of the radiologist, pathologist and other specialists as fundamentally hospital services, in view of the fact that with the rapid strides made by medicine certain essential services have become so associated with hospitals as to become, in the minds of the public, hospital services.

FINANCIAL INVESTMENT IS LARGE

By and large these services are those that can only be made available through the use of substantial space, expensive equipment, and trained technicians. The financial investment of hospitals in their specialist departments is much larger than is that of general practitioners in their facilities, and without such an investment on the part of others the specialist would be unable to engage in practice in the hospital. Certainly this is an element of real importance in determining a fair economic solution of the problem.

There is also the element of business production involved in the problem. The ordinary physician or surgeon must over a long period of time develop his patients and compete with other members of his profession in building up his practice. On the other hand, the hospital specialist, even though he is a stranger and new in the community, is given an effective monopoly on all of the business within his specialty that comes into the hospital. He is assured an immediate and continuous practice, regular hours,

From a paper presented to the Association of Western Hospitals, Seattle, 1950.

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and usually the receipt of regular fees during absence from the department as a result of illness, vacations and other causes. Surely other professional men, such as architects, engineers and attorneys, have no such position within which to practice their respective professions, and the value thereof is quite substantial and should be considered in arriving at a solution of the problem under discussion.

SPECIALIST'S POINT OF VIEW

However, we must also look at our problem from the point of view of the specialist. Many specialists feel that after taking a position with a hospital they have in many respects placed themselves at the mercy of the hospital administrator or its governing board owing to the fact that should they be discharged they are, in effect, put out on the street without any private practice or economic security. This has been the cause of considerable agitation by some specialists throughout the country. They claim that neither a lay administrator nor a lay governing board should have the right to pass on the manner in which they are to practice their profession.

It would appear that the specialist should have the right of having problems relating to the practice of medicine referred to the attending medical staff, but on the other hand all problems relating to hospital administration should be held under the jurisdiction of the administrator working under the policies of the governing board of the hospital. Where such protection has been granted to specialists many hospitals have been able to work out long-term contracts with provisions for termination upon reasonable notice, and of a nature, of course, that will not deprive the hospital of the right to terminate immediately where there has been professional misconduct.

Closely related to the question of financial security is the method of setting the fee schedules to be charged for professional services of specialists. It would appear that the specialists have become unduly alarmed about this matter. From a strictly technical standpoint the fees should not be established by a lay person or group of persons and where this point has become an issue it has generally been found that a referral of fee schedules to the attending medical staff or a committee thereof for final determination ends the difficulty. It is recommended that in all arrangements between hospitals and specialists a provision for such a referral in the event of disagreement between the two be included.

On the question of billing of fees for professional services of specialists, it has been ascertained that patients generally resent the receipt of a series of bills from different sources and from various practitioners whom they have never seen. On the other hand, the specialist is entitled to professional recognition in the matter of billing. Since multiple billing is both wasteful and uneconomic, as well as provocative to the patient, it is suggested that the accounts be assigned to the hospital for collection and that the hospital statements be made to indicate clearly that the items contained therein covering services of specialists are for services rendered by the particular specialist in charge of the respective department. This can be done by revising current statement forms in only a minor degree.

DIGNITY HAS BEEN HURT

Another factor that complicates the relationship between hospitals and their specialists is the feeling on the part of some physicians that they are being relegated to a secondary position in the medical profession in some hospitals. In certain instances they have indicated that owing to their close relationship to the hospital functions they have been treated by the members of the medical profession as ordinary hospital employes rather than as fellow members of the profession. In other words, their dignity has been hurt.

Logically, this should not be a problem of the hospital but since it is the basis of some of the demands of a few specialists looking to further independent recognition it should be given serious consideration by all administrators. Wherever possible, the specialists should be made regular members of the attending staff and the staff should be encouraged to include them in staff functions, including service on committees and the holding of offices. The presentation of papers or reports from time to time at staff meetings also helps this situation.

The foregoing suggestions would appear to be an indirect approach to the problem but as a matter of actual experience with a great many of these situations they have proved to be extremely helpful in those cases where the specialist is really troubled about his professional status and is not using a feigned loss of dignity to attain some economic advantage.

Unfortunately, it has appeared that much of the agitation and difficulty between the hospitals and their specialists has arisen purely as a result of the desire of the specialist for a greater share of the fees charged for his services. This does not mean that some specialists are not truly concerned about their status, but it has become apparent that others are simply using these questions as a basis for attempting to prevent the hospital from receiving its fair share of the fee. For this reason each hospital should be watchful and see that its arrangements with its specialists are properly handled so that it will not be subject to this type of approach.

An educational program with the attending staff is exceedingly helpful and it is believed that wherever possible the executive committee of the attending staff should be kept fully informed of the nature of the relationships with the hospital specialists so that in the event an issue is raised the hospital can look to it for support. By and large, it has been the rule that when fully advised, the members of the staff take an objective view and are of great assistance in opposing any unreasonable demands from specialists, for they are always concerned with any action that will affect their patients or increase the cost of hospitalization. On the other hand, if they have not been fully informed, they are inclined to be sympathetic to claims by the specialists that they have been imposed upon by the hospitals.

ADD FUEL TO THE FIRE

Both sides to this controversy can point to well written and logical legal opinions supporting their position. The American Medical Association has adopted a firm stand and the American Hospital Association has adopted a policy statement that is almost diametrically to the contrary. These statements may help to crystallize our thinking on this subject, but they also add fuel to the fire that is raging. This problem can only be solved at the local level, eliminating unnecessary issues that give rise to controversy but are unimportant.

We have been through more than our share of aggravated situations in California, and without exception the suggestions made have eventually resulted in a fair and satisfactory solution. Unquestionably, there will al-

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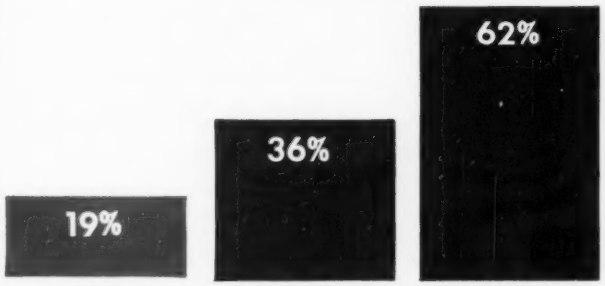

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ways be sporadic attacks from the ranks of the specialists but by and large these come from individuals who are not directly associated with hospitals and in the long run do the hospitals little harm.

In conclusion I wish to urge all parties concerned with this problem to adopt an objective point of view in reaching for a solution to the problem under discussion. First, we must consider the patient, and, second, we must consider the status of the medical profession in the eyes of the general public. Continued wrangling within the profession can only weaken our defense against those who would socialize the entire field of medicine. The stake is much greater than the feelings of a small group of individuals and they cannot and should not be allowed to jeopardize in any way the entire structure. On the other hand, those in the hospital field must do their part in being fair and reasonable in all respects as they approach this problem without bias or prejudice.

Successful operation of the pharmacy

depends upon cooperation with staff and administration

PAUL G. BJERKE
Pharmacist
Luther Hospital
Eau Claire, Wis.

IN ORDER for the department of pharmacy in a hospital to operate successfully, close harmony must exist among the pharmacist, administrator, nursing staff and medical staff. The keynote of this success is cooperation.

There are many ways in which the success of a pharmacy can be increased, making the department more valuable to the patient, physician and the hospital. To accomplish these things it is essential, first, that the pharmacist have the cooperation of the administrator, for without this his program cannot succeed. Many times it will be necessary for the pharmacist to have the approval and encouragment of the administrator; on the other hand it is also necessary for the pharmacist to know that he is in complete charge of the department. They must work closely together in the operation of the department.

A pharmacist in a hospital has an unusual opportunity to be of service to the patient and of value to the medical staff. To accomplish these aims and to conduct a successful pharmacy, certain basic policies and procedures should be developed. Of prime importance is the department's interest in new drugs and recent medical developments and its attitude as an information center.

The pharmacy is the logical information center about drugs for the medical and nursing staffs. This is the one service in which the pharmacist can excel and which he should give willingly. In order to become the information center, this department should maintain a file of all current information on drugs, which can be made readily available to the staff, and an adequate library so that reference books will be available. The pharmacist should receive the current and important pharmaceutical journals. After they are read they can be bound and used for reference. The department should carry on a limited research program so that a staff member can bring his dispensing problem to the pharmacist for solution. With these basic procedures, the department and pharmacist can play a vital part as the information center in any hospital.

To enlarge the scope of the department's information center, a bulletin for the medical staff can be issued. This, in my opinion, is one of the more valuable services the pharmacist can render to the staff. Today there are several news letters published in hospitals throughout the country. The makeup of the letters varies. Some contain several pages and deal with several drugs. Others, like the one I publish, is a single page, dealing with a single item or a few related items. The Luther Hospital *Medical Staff Bulletin* was first published on May 27, 1942, and the *American Professional Pharmacist* in the September 1948 issue credits it with being perhaps the first publication of its kind. This bulletin is published when something sufficiently important needs to be called to the attention of the staff. In this way it is always welcomed and takes relatively little time to read. Other types of bulletins may be as effective, or more so. However, the most important point is to publish a news letter and make it of significant interest.

An important phase of gaining staff cooperation is the teaching program for the intern and house resident physician. This can be of mutual benefit. The intern has learned little prescription writing in school and needs further teaching in this respect. He sees the dispensing problems of the regular staff and knows that soon they will be his. In whatever field he chooses to pursue, the knowledge of drugs is essential. He is eager to learn and a well conducted weekly conference can be of great value to him. This, in turn, is reflected in his work with the staff. These conferences can occasionally include pharmaceutical detail men, if the house staff desires, besides discussions by the pharmacist. Demonstrations in the pharmacy are sometimes of interest. An informal conference is preferred and questions are encouraged. This program has been enthusiastically received by the house staff members.

If this type of program is developed and used, the use of the pharmacy department will be greatly increased. The physicians should be encouraged to visit the department frequently, and when they come time should be taken to answer their questions and help them with their problems. An inquiry should never go unanswered, even if it requires writing for the information

or considerable time is involved in supplying the desired information. The physician is being furnished reliable and unbiased information by the hospital pharmacist, something which is often difficult for him to obtain. An excellent service can be rendered by the pharmacist when the physicians visit the pharmacy. This call is not merely a social one, but one in which the physician is always seeking information.

The respect of the medical staff can be won, and an invitation will soon be extended to the pharmacist to attend weekly clinico-pathological meetings and monthly staff meetings. The pharmacist is available there to answer any questions that might arise. Here, too, he again has made himself a close associate of the medical staff. These meetings should be attended regularly.

From the financial standpoint, the pharmacy is one of the revenue producing departments of the hospital. In order to produce revenue, the number of new and old drugs which are stocked must be kept to a minimum. With the research departments of every pharmaceutical company developing hundreds of new products, many of them similar or identical except for the trade name, a serious problem is developed in the hospital. It is not only a financial problem, but one that involves considerable space and causes much confusion with both the nursing and medical staffs. Here is the one place in which staff cooperation is essential. Again, if the pharmacist has established himself as an individual competent in his field, the task will be easier to accomplish. Theoretically, this department cannot be expected to stock every new product or identical products that are developed. But with many doctors on a medical staff, each can think that his problem is slightly different and that he is being limited in his prescribing habits if he is requested to use only certain drugs. Of course, this should not be done, but unless there is cooperation between the pharmacist and medical staff a most difficult situation is created. In discussing hospitals in the 100 to 300 bed size, we are assuming that a strict formulary procedure is not the method of choice. Here, again, human nature rebels at force, and physicians are no exception.

The appointment of a pharmacy committee may be an important asset to the pharmacy and to the medical staff. This committee, consisting of various representatives of the medical staff, should have a most important function. If there are several similar products, the pharmacist can present to the committee his findings on each, and let the committee decide which is best. This product can then be stocked in the pharmacy and the committee's recommendation is made known to the staff. It should be clear that if for any special reason a physician wants a similar product, it can be obtained but at a higher cost and resulting poorer service to the physician. In this way there are no "must" rules, but the procedure is of a suggestive nature.

The medical staff bulletin, besides informing the physician of new products and new services available, can render an important service by reporting comparative studies of various products.

The progress that can be made is great. With 57 staff members at Luther Hospital we use one type of repository penicillin. This is truly a good example of pharmacist-medical staff cooperation. It materially benefits the patient and the hospital and causes no confusion for the nursing staff.

As is true of other hospital services, continuous pharmacy service is essential. No matter how efficient the system might be, the pharmacist must expect night calls. This can be abused, but here again the pharmacist must be willing to serve the patient and the doctor. If there is more than one pharmacist on the staff, the night call burden is eased. With a single pharmacist, all calls must be answered and often considerable time is involved. It is one of the duties hospital pharmacists are glad to perform.

I have presented some of the things that have been developed in the pharmacy at our hospital. It has been the plan to make the department more valuable to the physician in treating his patients. By using many methods to keep abreast of medical progress, such as developing a medical staff bulletin, a house staff teaching program, enlisting help of a pharmacy committee, and the cooperation of the administrator, we have established a successful program. It is not a program which can be completed in a short time, but it can be started in a short time. Even with a carefully outlined program, it must be remembered that the key is cooperation. This is gained by faithful service and the desire of the pharmacist to serve.

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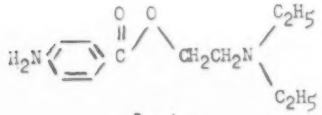
PROCAINE

IN THE year 1860, Niemann, a pupil of the famous German chemist, Wöhler, first isolated the alkaloid cocaine from the leaves of the Erythroxylon coca tree which grows in Peru and Bolivia. For centuries, the natives of these South American countries have chewed the leaves of this tree to decrease hunger and to increase endurance, for the drug is a central stimulant.

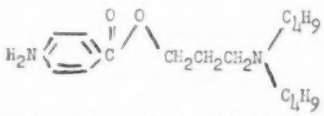
Nineteen years after it was isolated, the drug was investigated by von Anrep, who discovered that following subcutaneous injections the overlying skin becomes insensitive to the pricking of a pin. The clinical world did not immediately act upon von Anrep's suggestion that cocaine might be useful as a local anesthetic. Another five years elapsed before Köller in 1884 demonstrated the action of the drug on the cornea of the eye at the Ophthalmological Congress at Heidelberg. But, thereafter, the acceptance of cocaine as a local anesthetic was immediate. In the same year, Hall introduced local anesthesia into dentistry, and the following year Halsted laid the foundation for block anesthesia in minor surgery when he demonstrated that cocaine will block the transmission of impulses along nerve trunks.

In 1892 Einhorn began a series of investigations in an attempt to synthesize new compounds similar to cocaine which would have local anesthetic properties. Beginning with the study of certain organic esters, he came, in 1905, upon the drug "Novacaine" (since named procaine), which has remained to this day the most popular and probably the safest of all local anesthetic agents.

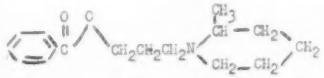


Procaine

The molecule is seen to contain: (1) an aromatic organic acid, in this case p-aminobenzoic acid; (2) an ester linkage, in this case an ethyl ester, and (3) a tertiary amine, here the diethylethanol amine. In the years since 1905, a wide variety of local anesthetic agents have been synthesized on this same general pattern by employing different acids, different esters, and different tertiary amines. A few examples would include:



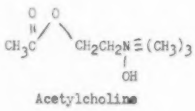
"Butyn," the propyl ester, di-butyl substituted amine



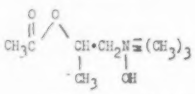
"Metycaine," benzoic acid, propyl ester, methyl-piperidino ring

Mechanism of Action of Procaine and Related Drugs: A question of fundamental interest to pharmacologists is: "How does a given drug interact with the tissues of the organism so as to produce the observed changes?" The principal action of procaine and the other local anesthetic agents is to impede the transmission of nervous impulses at any point of the central or peripheral nervous system at which the agent is applied. In 1943, Thimann suggested that local anesthesia is due to competition of the drug with acetylcholine for the excitable substrate. In the light of this suggestion, we are led to examine more closely the molecular structure of these various competing substances, and an interesting parallelism becomes apparent.

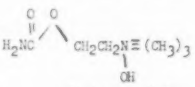
Acetylcholine and other parasympathomimetic amines are straight-chain or aliphatic compounds, with structures as follows:



Acetylcholine



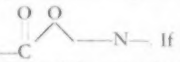
Acetyl-beta-methylcholine (Mecholyl)



Carbaminocholine (Doryl)

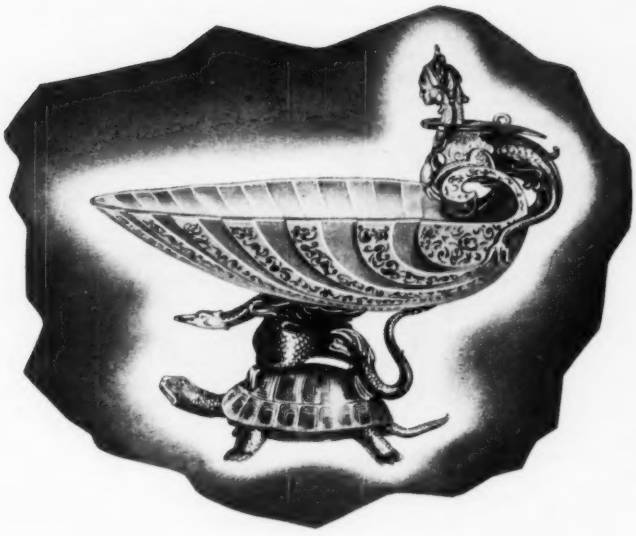
In addition to being aliphatic, these three compounds have another feature in common—the spatial arrangement of certain chemical groups. That is, they contain a carboxy-ester linkage separated from a quarternary nitrogen by a two-carbon chain. We can shorthand this arrangement with the symbol

Now if we return to the structural formulas of procaine, butyn and metycaine we notice immediately certain similarities and certain differences. Each of the three compounds contains a carboxy-ester linkage separated from a *tertiary* nitrogen by a chain of either two or three carbons. Again we can symbolize the spatial arrangement as



If not identical, it is certainly very close to the symbol for the parasympathomimetic amines. But whereas the active amines are aliphatic compounds, each of our anesthetic agents contains an aromatic ring. Now, aromatic rings are known to alter the activity of functional groups attached to them, and in addition they have a space-occupying property.

In terms of our present conceptual models of molecular structure this



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Once in a long while a remedy is evolved which meets practically all of the medical requisites: effective, safe, and reliable. In the management of peptic ulcer or hyperacidic conditions, GELUSIL* 'Warner' by combining comparatively non-reactive aluminum hydroxide gel with magnesium trisilicate, provides the advantages of both.

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TABLETS—each containing magnesium trisilicate, 0.5 Gm (7.5 grains) and dried aluminum hydroxide gel, 0.25 Gm (4 grains): boxes of 50 and 100, and bottles of 1000 tablets.

LIQUID—magnesium trisilicate, 0.5 Gm (7.5 grains) and aluminum hydroxide, 0.25 Gm (4 grains) per 4 cc (1 teaspoonful): bottles of 6 and 12 fluidounces.

[1]Seley, S. A.: Medical Management of Pyloric Obstruction Resulting from Peptic Ulcer, *Am. J. Dig. Dis., 13*:238, 1946.

*T. M. Reg. U. S. Pat. Off.

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means that the carbon atoms of an aromatic ring are not co-planer. While the carbon atoms of a "straight chain" compound are probably not in a straight line, they may well be arranged in a regular zigzag so that all atoms could be aligned on a given plane. This is not so with a ring structure, which we consider to be bent up at the ends so as to occupy space in all three dimensions.

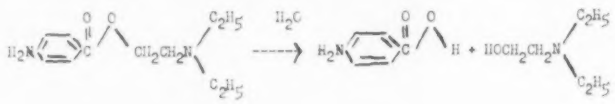
Thus, in our anesthetic agents we have molecules that are in the center similar to and at the ends different from acetylcholine. At one end the quarternary nitrogen has been modified to a tertiary nitrogen. At the other end an aliphatic group has been replaced by a ring which may alter the action of the carboxy group, owing either to its chemical properties or to its space-occupying properties, or both.

In order for a drug to interact with an organism, it must, we assume, first reach and attach itself to some specific receptor site and then, having so attached itself to the site, it must proceed to alter chemically or electrically (which is probably synonymous at the atomic level) the local equilibrium. For purposes of argument let us assume that there exists at various places in the organism a certain excitable substrate which has receptor sites corresponding to the pattern

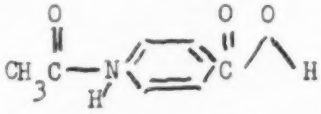
Any compound containing this particular configuration can then attach itself to those sites, whether it is acetylcholine, mecholyl, procaine or metycaine, and thus the first criterion of drug action is satisfied.

But whether or not and to what extent the local equilibrium is disturbed will be dependent upon the chemical nature and activity of the functional groups of the attached molecule. We can explain the observed phenomena by saying that the quarternary nitrogen and the aliphatically substituted carboxy-ester group are sufficient and adequate to disturb the equilibrium in the direction which we call stimulation. Apparently the tertiary nitrogen and aromatically substituted carboxy-ester group are not sufficient and adequate to produce stimulation. And finally any receptor site which is occupied by a molecule of procaine is not at that moment available for occupancy by a molecule of acetylcholine.

The Fate of Procaine: Procaine is metabolized by the body in a series of chemical transformations, of which the first two are fairly well understood. Procaine is an ester. When it comes in contact with blood, liver, lung, or mucous membrane, it is hydrolyzed into its substituent parts—p-aminobenzoic acid and diethylaminoethanol.



The p-aminobenzoic acid is then alkylated, probably acetylated to



p-acetylaminobenzoic acid. This compound is then in part excreted in the urine, and in part utilized in the normal metabolism of the organism. The ultimate fate of the diethylaminoethanol is still unknown.

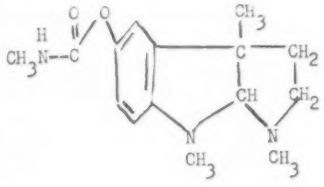
The concentrations of both procaine and p-aminobenzoic acid in various body fluids can be readily determined by means of the Bratton-Marshall method devised for sulfa determinations. The technic consists of diazotization of the p-amino groups by means of sodium nitrite in an acid medium, and subsequent coupling of the diazonium salt to a color-producing molecule such as N—(1-naphthyl)—ethylenediamine dihydrochloride. The concentration of drug is directly proportional to the optical density of the resultant dye solution as measured photometrically. Procaine can be separated from p-aminobenzoic acid by extraction with a non-polar solvent such as chloroform or ethylenedichloride in an alkaline medium.

Investigation of the *in vitro* hydrolysis of procaine by whole blood, plasma, serum and homogenates of body tissues has shown that the splitting of the drug is enzymatic in nature. Heating the fluid or tissue to 60° C. for one hour prior to the addition of procaine to the system will markedly decrease the enzyme activity, that is, the rate at which the system will then hydrolyze procaine. Addition of such enzyme poisoning agents as fluoride or arsenite to the system will halt nearly all of the enzyme activity. Fractionation of whole blood has shown that the enzyme is present in the plasma phase but not in the red or white cells. Within the plasma it has been further localized to the serum albumen fraction of the protein.

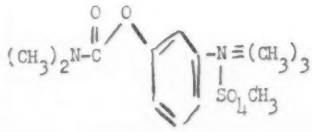
Bruno Kisch has defined a quantity which he calls the "Procaine Esterase Index" (PEI) for purposes of comparing the enzyme activity of serum from different individuals, different species, and different circumstances. Using the procaine esterase index as a means of comparison, he demonstrated that human blood is far more active than the blood of any other species that he investigated in its ability to split procaine. He found that the esterase activity of human blood is about seven times greater than that of dog blood. He further showed that liver is about twice as active as blood and that both lung and *mucous membrane* (vide infra) show considerable esterase activity. On the other hand, brain, kidney, adrenal gland tissue, cerebral spinal fluid, sweat, tears, saliva and urine showed no procaine-hydrolyzing properties.

In addition, he demonstrated that the serum from hyperthyroid patients shows a significant increase in PEI, while serum from patients with gastric malignancy has a significant decrease in procaine esterase index.

Eserine or prostigmine methyl sulfate added to serum will decrease its PEI. The formulas for these compounds are as follows:



Eserine



Prostigmine Methyl Sulfate

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Essenamine "Pick-me-up" — the following eggnog recipe (just one of many in the Essenamine recipe book) supplies 60.8 Gm. of protein in an appetizing beverage:

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Essenamine	4 tablespoonfuls	
Sugar	2 tablespoonfuls	
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*Guerriero, W.F.: *Texas State Jour. Med.*, 45:274, May, 1949.

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pattern—a carboxy-ester group separated from a tertiary or quarternary nitrogen by a distance corresponding roughly to the length of a chain of two or three carbon atoms:

But in these two compounds the "separator" is a resonant aromatic ring, while in procaine and the other compounds previously considered the separator was a straight aliphatic chain.

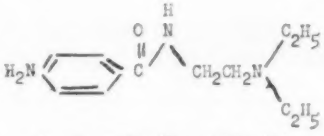
So our picture of the procaine esterase shapes up to resemble our picture of the excitable substrate with which acetylcholine is thought to interact. We can imagine that each of these substances, the esterase and the excitable substrate, comes equipped with receptor sites which will receive molecules that possess the configuration  . In the next step of the interaction we see an apparent difference between the esterase and the excitable substrate. When the appropriate substance is presented to the esterase, the change we see occurs in the substance—hydrolysis. When the appropriate substance is presented to the excitable substrate the change we see occurs in the substrate—excitation. Now it may well be that this difference is more apparent than real owing to the vantage point from which we are observing the phenomena. After all, it would seem a contradiction of terms to speak of an interaction between substances, and then turn around and say that one substance is changed and the other is not. We are more aware of the change in one than in the other.

Be that as it may, we can postulate that eserine and prostigmine methyl sulfate molecules are capable of attaching themselves to receptor sites on the esterase, but are not capable of then undergoing hydrolysis. Since sites occupied by eserine cannot simultaneously be occupied by procaine, the hydrolysis of procaine is slowed by the addition of eserine to the *in vitro* system.

Another question that comes to mind is: "What is procaine esterase, really?" The obvious idea that it might be one and the same with choline esterase is apparently not so. The evidence for dissimilarity may leave something to be desired, but it is strongly suggestive. Kisch worked out activity series for both the procaine and choline esterases and demonstrated that the relative indices for these esterases were not parallel through a series of species investigated. He also showed that while choline esterase is present in red cells, procaine esterase is present only in the plasma phase of blood. If the two substances occur in mutually exclusive places, then they must in fact be different substances.

On the other hand, it is a little hard to believe that God, in His infinite wisdom, provided us with an enzyme specific for a substance which was not invented until the year 1905. We do not at present have a satisfactory answer to our question.

That the enzyme is in fact an esterase is strongly suggested by recent work with procaine amide, which differs from procaine only in that it has an amide linkage instead of an ester linkage.



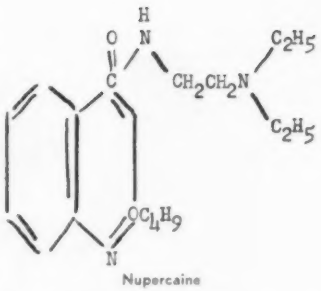
Procaine Amide (Pronestyl-Squibb)

Procaine is hydrolyzed very rapidly by whole blood. One cubic centimeter of blood will split about 2.5 micrograms of procaine per minute at 37° C. over rather wide ranges of procaine concentration. Thus, the six liters of blood in an average man, if acting *in vitro*, would hydrolyze 50 mgm. of procaine in a little more than three minutes, 150 mgm. in about 10 minutes, and 250 mgm. of the drug in 16 minutes. *In vitro* studies with procaine amide show no demonstrable hydrolysis after four *hours*. "Pronestyl" may thus be used in oral dosage to prevent cardiac arrhythmias as a long-acting procaine substitute.

Though the anesthetic properties of procaine amide have not been adequately investigated, it is interesting to speculate that the ester linkage is probably not essential to the anesthetic action since nupercaine, a drug of high local anesthetic potency, is an amide, not an ester.

Methods of Administration: In the light of our previous hypothesis, let us now reconsider what is known of the effects of procaine on the human organism when the drug is administered by various routes.

First and foremost, procaine is an infiltration anesthetic. Since procaine



Nupercaine

does not show the vasoconstricting properties of cocaine, it has long been recommended that procaine be administered in conjunction with small amounts of epinephrine. The vasoconstriction has the dual effect of preventing locally injected procaine from being mechanically carried away from the site of injection by the blood stream, and also of preventing hydrolysis of the drug by the blood. (We also know that epinephrine has a slight anesthetic effect possibly owing to its ability to counteract the effects of acetylcholine.)

Procaine has not proved to be a successful agent for topical administration to mucous membranes. In the past this has been explained on the basis that procaine has "poor penetrating power." Perhaps a better explanation is that mucous membranes have a high concentration of procaine esterase, so that the topically administered drug is hydrolyzed before it has time to reach a site of action.

Attempts to give procaine orally are triply doomed to failure. The alimentary mucous membrane contains procaine esterase. Should the drug pass that barrier, it is next picked up by the blood, which is also high in esterase. It is then carried to the liver, the organ richest in procaine esterase. Hence, it is not surprising that following oral administration to man, in doses as high as 2 grams, no blood level of procaine is detectable. In the dog, on the other hand, oral administration of 40 mgm./kg. gives a blood level which reaches a peak in one-half hour and tapers off smoothly over a period of two hours. But then the dog has a procaine esterase level of only one-seventh that found in man.

Procaine has long been used for spinal anesthesia. This is made possible by the fact that spinal fluid has practically no procaine esterase activity.

Although procaine was used intravenously as early as 1907 by Bier and intraarterially by Goyannes in 1908,

it was not until the middle 1930's that a group of French workers popularized the slow intravenous drip technic for administering the drug. It was used in a wide variety of complaints including serum sickness, asthma, pruritus, and the relief of pain following burns, trauma and surgery. In 1940, Rovenstine demonstrated that intravenous procaine was a valuable agent for the control of cardiac irregularities during surgical anesthesia. More recently he has shown that procaine amide is preferable to procaine for this purpose because of its low toxicity, slow destruction, and possibility of oral administration.

Both procaine and procaine amide show a quinidine-like action on the heart—that is, they reduce the irritability, prolong the refractory period, slow the heart rate independently from the vagus nerve, and cause an increase of cardiac filling.

For continuous intravenous administration, Graubard has defined the Procaine Unit as 4 mgm. of procaine per kg. of body weight in 20 minutes. This corresponds to the rate at which procaine would be hydrolyzed *in vitro* by the whole blood of the subject.

In vivo procaine disappears from the blood stream far more rapidly than this. Two minutes after the rapid intravenous injection of 150 mgm. of procaine, none can be found in the blood stream. On the other hand, immediately after the rapid intravenous administration of procaine amide there can be found a blood level about one quarter of the value that would be expected if the amide were evenly distributed through the blood. This suggests that the procaine amide, and presumably procaine, is rapidly distributed through both the blood and extracellular fluid compartments.

If this is indeed the case, it carries the implication that the blood level of procaine does not parallel the systemic action of the drug. Procaine is hydrolyzed far more rapidly by blood than by extracellular fluid. If some intravenously administered procaine is distributed to the extracellular fluid before it has been hydrolyzed, it could still be intact and active while that in the blood is almost entirely split. Then if a reverse gradient were established and procaine began to diffuse back into the blood stream, there to be rapidly destroyed, it would be possible to produce marked systemic effects although the blood level remained low for all except the moment of injection. This may be an entirely erroneous explanation, but it is compatible with the phenomena thus far observed.

Side Effects of Procaine: Sadove has proposed a classification for procaine side effects as follows:

REACTIONS SEEN IN NORMAL INDIVIDUALS

A. Central nervous system
   1. Stimulation—nervousness, apprehension, tremors, convulsions
   2. Depression—less common
B. Cardiovascular system
   1. Myocardial failure—related to quinidine-like action of the drug
   2. Epinephrine-like effects—tachycardia, increased peripheral resistance
   3. Effects of altered CNS control

REACTIONS SEEN IN ABNORMAL INDIVIDUALS

A. Idiosyncrasy—reactions same as above, but to far smaller doses of the drug
B. Allergy—eczematoid sensitization

REACTIONS NOT DUE TO DRUG

Neuresthenic and hysterical

All of the reactions shown for normal individuals can be accounted for on the basis of the quinidine-like action or the acetylcholine-inhibiting properties of procaine. Differential sensitivity of the various parts of an individual will determine which manifestations will first become prominent, and this cannot be predicted, for it will vary from individual to individual.

Idiosyncrasy or abnormal sensitivity to the drug is a rather uncommon, but distressing, property of some individuals. Also there are some individuals who show such signs as tachycardia, cold sweat, and even syncope at the mere thought of an injection or the sight of a syringe. Such reactions cannot be properly blamed upon procaine or any other specific substance.

The eczematoid type of allergic response to procaine is frequently encountered in dentists and others who come in repeated contact with the drug. It is a cutaneous reaction, a form of specific contact dermatitis. The term eczematoid sensitization is used to cover allergic response to small chemical molecules of a particular type. According to one explanation for the phenomenon, these small molecules act by coupling to molecules of native body protein and thereby altering them so that they become antigenic. Others in the series are the catechol, erushiol, the active principle of poison ivy, p-phenelenediamine, and 2-4 dinitrochlorbenzene. Each of these substances contains at least one chemically active side group which could facilitate coupling to a protein, if indeed that is the mechanism. In procaine, perhaps it is the p-amino group which is responsible.

This, then is procaine, a simple, useful, and interesting drug. Its study leads us to many fascinating questions, any number of which still remain to be answered.—HENRY H. SWAIN, B.S., and C. C. PFEIFFER, M.D.

Effects of Smoking

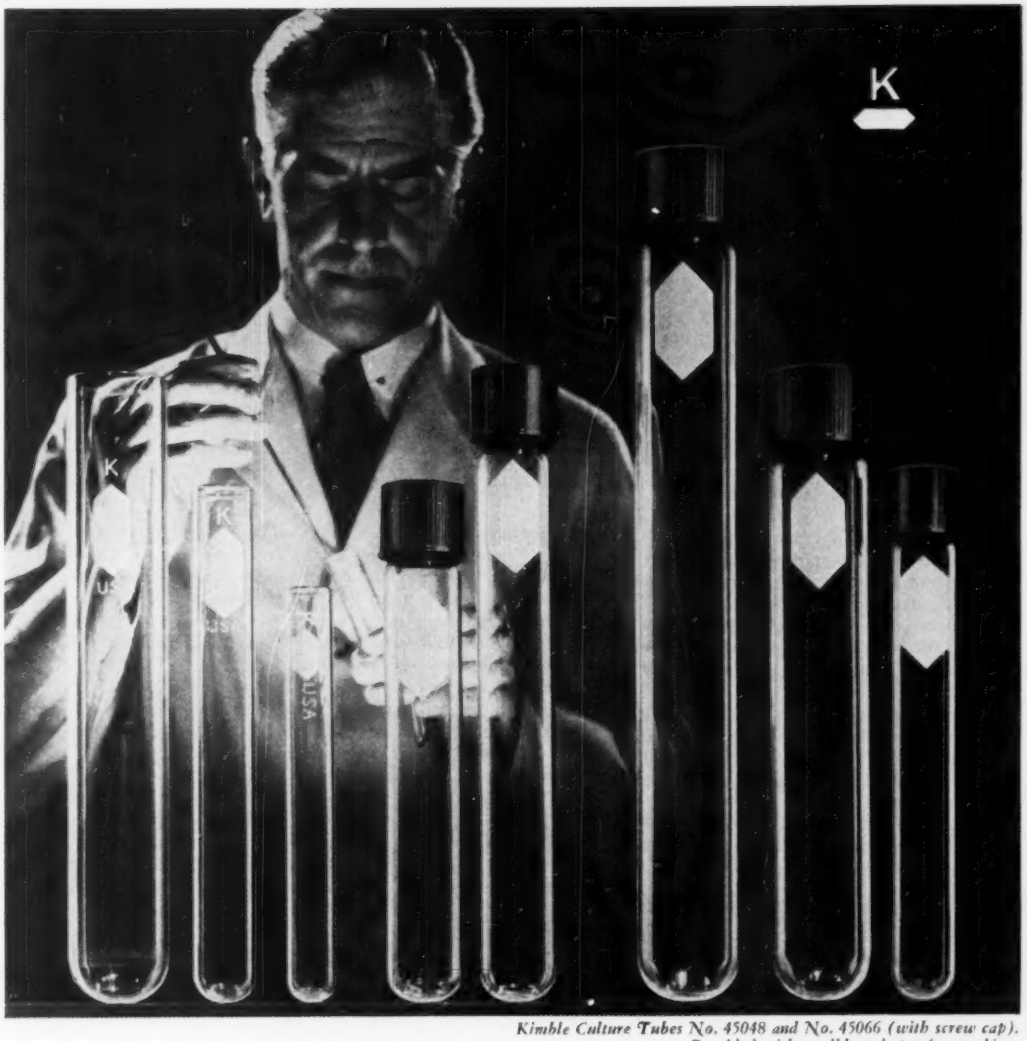
Two separate controlled statistical studies on the relationship of smoking to the occurrence of neoplasm of the lung are presented in the May 27, 1950, *Journal of the American Medical Association.*

The first article "Tobacco Smoking as a Possible Etiologic Factor in Bronchiogenic Carcinoma" by Ernest N. Wynder and Evarts A. Graham, M.D., is an evaluation of three studies of the smoking habit of 684 proved cases of neoplasm and 780 cases without cancer. The authors further limited their studies to 605 of the positive study group who had epidermoid and undifferentiated carcinoma of the lung. Of these cases, 96.5 per cent were moderately heavy and chain smokers as against 73.7 per cent of the men in the control group; 51.2 per cent of the neoplastic group were excessive or chain smokers as against 19.1 per cent of the controls.

Ninety per cent of the patients with proved neoplasm had smoked for more than 20 years and 94 per cent smoked cigarets.

The second article "Cancer and Tobacco Smoking" by Marlon L. Levin, M.D., Hyman Goldstein, M.D., and Paul R. Gerhardt, M.D., substantiates many of the foregoing conclusions. In a study of 1045 cancer patients (236 with cancer of the lung), it was found that "cancer of the lung occurs more than twice as frequently among those who have smoked cigarets for 25 years than among other smokers or nonsmokers of comparable age."

Both articles present rather strong evidence that the excessive use of tobacco, especially cigarets, may be a factor in the induction of bronchogenic carcinoma.—J. D. THOMPSON.



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ELECTRONIC COOKING

EXPERIMENTAL work is being conducted at the research division of the Quartermaster Corps in Chicago, Bayonne Navy Base, Veterans Administration Hospital, Washington, D.C., Massachusetts Institute of Technology, Cornell University and Teachers College, Columbia University, in electronic cooking. (38) An electronic range developed at Waltham, Mass., is being used by the experimenters. The range operates on an assigned frequency of 2450 megacycles with a wave-length of 2½ inches.

Cooking utensils must be of plastic, earthenware, china or glass since energy goes through these materials, immediately heating the food, but leaving the dishes and walls of the oven cold. This energy does not penetrate metal. The only heating of utensils is in longer process cooking when the utensil is heated by conduction from the food. (This was also observed at demonstrations conducted at the Washington State College, Pullman, last spring.)

Electronic cooking was first used for short-order cooking; however, since cooking is too fast for browning, steaks and chops are seared first and in 45 seconds are finished rare, or are well done in 1½ minutes. The time of cooking increases with the weight of the food but does not double. One potato bakes in from 2 to 4 minutes, and 5 pounds—12 to 14 potatoes—bake in 10 to 15 minutes.

At Teachers College all types of prepared dishes, macaroni and cheese, chili, fresh and frozen vegetables, meat dishes, roasts, puddings and cereals were tested. Forty-ounce packages of frozen vegetables were wrapped in parchment paper and in from 6 to 10 minutes were thawed out and cooked, retaining original flavor and color. Chickens and meats were roasted in from 10 to 25 minutes depending upon the size. Spanish rice was made with one pound of minute rice, and was finished in 10 minutes. No blanching or washing was required and there was no packing or starchy consistency in the finished product. Fruits, jams, jellies and tomatoes were canned by the oven method and required only 1¼ to 2 minutes per pint jar.

The most immediate commercial utilization is the installation of radar mats. These are being established on a commissary plan where foods are cooked to 85 per cent completion, packaged by portions, and delivered in refrigerated trucks to the radar mats. Here a customer orders any meat and two vegetables appearing on the menu. These are removed from the packages and finished on the serving plate in 45 seconds, thus eliminating losses in steam-table holding and resulting in speedier service of well cooked foods.

Tremendous savings of nutrients have been reported in the electronic blanching of foods and also in preparation of commonly used meats and vegetables. (39) Retention of nutrients was determined in the preparation of beef patties, pork patties, beef roasts, cabbage, carrots, broccoli and potatoes, both by the electronic range and by conventional methods: boiling, pressure cooking, and baking for vegetables, and grilling and roasting for meats. For vegetables, the amount of water used had the greatest influence on the retention of water-soluble nutrients; the pressure cooking technic resulted in superior retention as compared to the boiling water and electronic range technic. Thiamine retention was higher in meat patties cooked electronically than it was when they were cooked by grilling. Niacin and riboflavin were equally stable in both methods of cooking. Beef roasts showed slightly better retention of thiamine, riboflavin and niacin when prepared in the oven than when in the electronic range.

ANTIOXIDANTS

With preservation by freezing and cold storage ever-increasing, the use of antioxidants has become, more and more, the subject of experimental work. Antioxidants in preserving lards and sausage (40) are especially important, owing to the absorption and reaction of fats and oils with oxygen. Rancidity develops from products, known as peroxides, formed during oxidation, and it may be accelerated by moisture, heat, light, air or metallic catalysts such as copper. It will develop even though a product may be in an air-tight wrap, for the breakdown of fat itself produces the oxygen that causes rancidity, and may go on slowly under zero refrigeration.

A synergist antioxidant was developed, containing propyl gallate, lecithin, corn oil and citric acid, which exerts a greater effect than when each is used singly. In food products con-

This is the second section of a study on food processing, packaging, preparation and storage. The first appeared in the October issue.

Sexton

Appetizing

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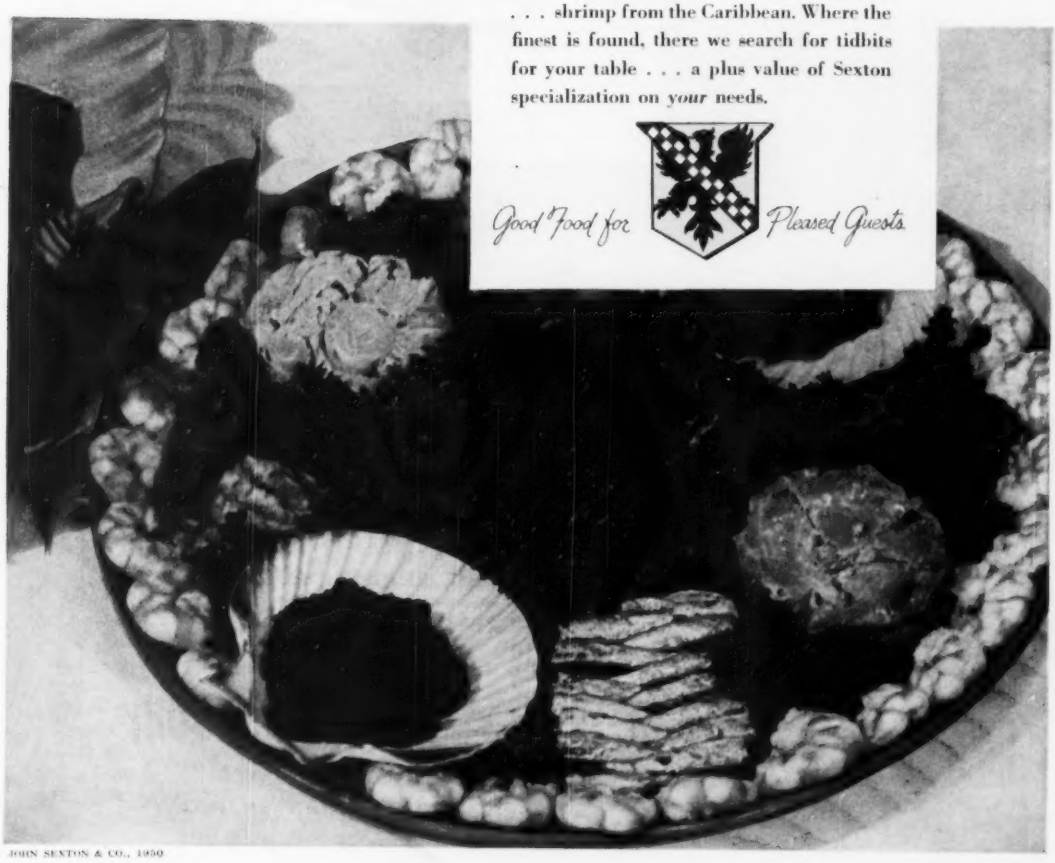

one food conveyor gives you dozens of inset arrangements for your selective menus

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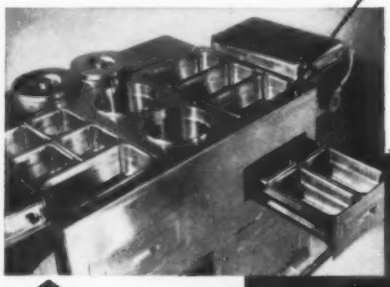
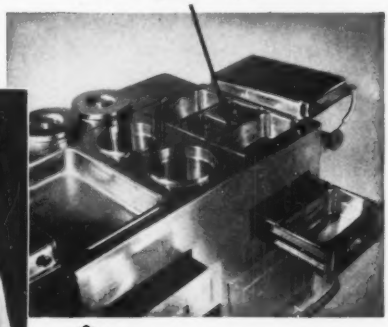
▲ EIGHTEEN square and rectangular stainless steel insets in various sizes can be arranged in many combinations.

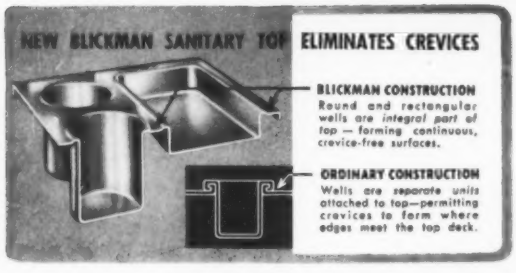


▲ *Above:* Today's menu may call for four square and four rectangular insets as shown here.

Right: While tomorrow, square and rectangular insets may be arranged like this. ▶



▲ *Above:* Still another arrangement is shown. Note the heated drawers and the convenient serving shelf.



SEND FOR ILLUSTRATED BOOK

explaining merits of the "Selective Menu" and describing this and other Blickman Food Conveyors.

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taining fat it is only necessary to protect the fat in the product, therefore the correct amount of antioxidant needed is correlated with the fat content of the product. The salt in the seasoning for fresh pork sausage hastens rancidity; the antioxidant, if mixed with the seasoning, holds down the oxidation caused by the salt, and is able to keep sausage stored for six to eight months without appreciable loss of flavor or color. The antioxidant, mixed with corn, cottonseed, peanut oil or lard, is used in coating ham, bacon and other meat products thus stabilizing the surfaces. Meat must be smoked first, since antioxidants cannot be used in a "cure" as they prevent the oxidation of the nitrites necessary in producing the color and flavor of a cure. When combined with salt, the antioxidant mixture can be used in salting potato chips, nutmeats, corn chips, popcorn, peanut butter, and so forth.

Other experimenters (41) have found that synergist antioxidants which were highly effective on fat not in contact with hemoglobin had no retarding effect on fats in contact with hemoglobin or muscle extract solutions. Ascorbic acid which was oxidized before being brought into contact with the fat markedly protected the fat.

A comparative study (42) of varying amounts of ascorbic, citric and dihydroxymalic acids showed that citric acid had no significant value in preventing oxidation or in reducing the amount of ascorbic acid required for frozen peaches, apricots, cherries and prunes. Citric acid did improve the flavor and tartness of low-acid fruits. However, when used with apricots or peaches it gave an adverse effect. Ascorbic and dihydroxymalic acids were equally effective as antioxidants for frozen fruits; 150 mg. ascorbic acid per pound of fruit proved effective; higher proportions were of little value. Retention of ascorbic acid was good after extended storage at —4°F.

In another comparison of sugar solutions with and without antioxidants used in the freezing of fruits, the addition of l-ascorbic acid to sirups improved both the color and flavor of frozen apricots and peaches. (43) The authors suggested 250 mg. per pound of apricots, and 380 mg. per pound of sliced peaches. Although the addition of sodium bisulfite to the sirup had a slight tendency to improve flavor and color retention in apricots, the sodium bisulfite had a definite tendency to bleach the anthocyanin pigment of peaches and nectarines. Fruit that is allowed to thaw standing in the drained sirup will increase in sugar content at the cost of the sugar content of the sirup. Ascorbic acid in an apple juice solution added to apples during or after milling but before pressing delays oxidation long enough to permit removal of the oxygen and inactivation of enzymes. (44)

The addition of a new antioxidant, sustane, to animal fats and oils is said to give protection against rancidity for longer periods of time, and is particularly effective in lard. (45) Stored at ordinary temperature and without oxidation inhibitors, lard usually turns rancid within a short time. Sustane is a high grade of butyl-hydroxy-anisole; it is very soluble in oils and shortenings and thus provides no mixing problems. It imparts no detectable odor, color or flavor to the fats, and is not greatly affected by slight alkalinity which is an advantage in some baking mixes. It also carries through the baking process and protects the finished product against rancidity. The concentration is 0.01 per cent or 1 pound per 10,000 pounds of lard; where carry-through is not required, a much lower concentration suffices.

VITAMIN RETENTION

Studies were made of tenderness, palatability and thiamine and riboflavin content of beef (46, 47), as affected by roasting, pressure saucepan cooking and broiling. Thiamine and riboflavin retentions were also determined in the pan broiling of bacon (48) and pork sausage (49). In general, the results of all the studies can be summarized as follows: palatability was superior in oven roasts; tenderness was essentially the same in roasts prepared by any methods; losses in weight during cooking were greater with high temperatures (internal temperature of 209°F); the saving in total vitamin value by roasting at low temperatures was of practical value only for thiamine and niacin in pork and possible niacin in beef; pressure saucepan cooking retained more thiamine and less riboflavin. Oven-broiled bacon retains more thiamine than does pan-broiled bacon, while riboflavin retention is essentially the same by either method. Thiamine and riboflavin retentions in pork sausage were essentially the same when pan-broiled with or without water.

The method used in thawing frozen steaks was also found to have some effect upon their palatability and vitamin content. (50) Steaks thawed in the refrigerator, at room temperature, and at 73°C. were comparable in palatability; those thawed in water were less desirable from the standpoint of juiciness of the meat and flavor of the fat. Thiamine, riboflavin and niacin were retained equally well by all methods of defrosting, but pantothenic acid was retained best by defrosting in the refrigerator.

INFLUENCED BY STORAGE

Preservation of quality in unshelled peas, snap beans and strawberries, as judged by per cent retention of ascorbic acid, was found to be influenced by the method of storage. (51) When held under cracked ice, the peas and snap beans retained 40 and 60 per cent more of their original ascorbic acid than they did when stored at room temperature. Strawberries retain their high ascorbic acid content as long as they remain edible, regardless of whether they are chilled or stored at room temperature; refrigeration, however, markedly retards deterioration.

Ascorbic acid retentions in muskmelon were higher after freezing and freezer storage when packed in a 40 per cent sugar sirup. The losses in grapefruit sections packed with or without sirups were not significant. (52)

The effects of large-scale methods of preparation on the vitamin content of foods are of special importance to those concerned with institutional cooking. On the basis of preservation of reduced ascorbic acid, it is recommended that cabbage be shredded for coleslaw rather than minced and that the slaw be served as soon as possible after preparation, particularly if French dressing has been added. A much higher retention of water-soluble vitamins is obtained in cooked cabbage if it is steamed; if cabbage is to be boiled it should be done in a small amount of water and only until done. (53) Retention of thiamine, riboflavin, niacin and reduced ascorbic acid was higher for corn on the cob when it was steamed than when it was boiled. If the corn was removed from the cob and boiled, much greater losses of thiamine and riboflavin were observed as a result of leaching. (54) Again in the case of spinach, the greatest retentions were observed by steaming. Losses of ascorbic acid were caused chiefly by destruction; of riboflavin and niacin by

leaching, and thiamine was lost both by destruction and by leaching.(55)

Although little work has been done regarding normal human requirement of folic acid under different physiological conditions, the recent discovery of the importance of folic acid in the treatment of various types of anemias led to study of the effect of cooking on the folic acid content of eggs.(56) The average potency of raw egg was found to range from 13 to 27 mcg. per 100 grams. (Dietary intake of folic acid by the hen has been found to influence the concentration in the egg.)

Heat was found to be the major factor in loss of folic acid in the methods tested: scrambled, fried and poached. One-third to one-half of the vitamin was found in the egg white but cooking resulted in greater losses, which would suggest that the folic acid in egg white is in a more labile form. Of the methods tested for cooking the whole egg, no one method was preferable. The total contribution of a cooked egg once a day was found to be from 5 to 7 mcg. of folic acid. The riboflavin content of eggs was found to be stable to light, and as above, heat was responsible for its destruction.(57) Hard cooked eggs showed the least destruction, while the greatest was observed in soft meringues, probably because of the large surface exposed to heat.

MISCELLANEOUS TOPICS

Various milk solids were added to a basic fondant and were found to increase moisture retention in 10 per cent proportions.(58) The milk solids tested included whole milk, skim milk, buttermilk, whey, cream, lactalbumin and casein; the last was an exception at the 10 per cent level, increasing the viscosity so much that it could not be cast into molds. Since the base was composed of carbohydrates, the results indicated that the noncarbohydrate fraction of the milk powders was mainly responsible for moisture retention. Although they are beneficial in retaining moisture, their use is somewhat limited by their physical composition, flavor and color.

In a review (59) of problems in candy technology, the following were discussed: (1) The nature, cause and prevention of graying or fat bloom in chocolate candies. The chocolate bloom was attributed to segregation and crystallization of the higher melting fractions of the cocoa butter. The migration of this compound to the surface occurs readily at higher temperatures through the medium of liquid fats and crystallization of solid fat that results upon cooling. (2) Prevention of stickiness and graining or crystallization of hard candies. Correction was attempted by using surface coatings to reduce or prevent moisture absorption by the sugar when it is in a glassy state. Agents also have been included in the mix to stabilize a higher moisture content of the candy and thus decrease the tendency of the candy to absorb additional moisture from the atmosphere. (3) Elimination of the development of stickiness and graining in marshmallows. This study has only recently been initiated. (4) Prevention of moisture loss and mottling in bonbon coatings. The effect of adding hydrophilic agents to restore proper moisture content of bonbon coatings is currently being investigated.

Darkening of acid foods during heating was attributed to breakdown products of the degradation of sugar which proceeds simultaneously with inversion.(60) Under acid conditions, levulose produces discoloration to a greater extent than does dextrose, which seems to have an inhibiting effect on the inversion of sucrose. The color is due to the production of hydroxymethelfurfural and levulinic acid;

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Here, in one of St. Luke's floor pantries, toast is made in a 4-slice "Toastmaster" Toaster. Then it's quickly placed on a tray, checked by the floor dietitian shown, and served. Thus, toast reaches patients hot, fresh, and delicious.

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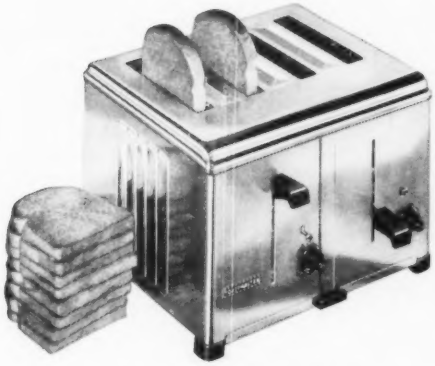
serves every slice hot, fresh, and crisp!



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AT ONE TIME all toast was made in main-kitchen range broilers. Breakfast toast was therefore made well in advance of serving, sometimes as much as two hours ahead. The result, of course, was cold toast—either dried out or soggy.

IN 1946, ST. LUKE'S began putting "Toastmaster" Toasters into "floor pantries" or diet kitchens. Today, there is a "Toastmaster" Toaster in every floor pantry on each of this great institution's 17 patient floors. Foods prepared in the main kitchen reach these floor pantries by dumb-waiter. Toast is made in the floor pantry just before trays go to patients, is the last item on the tray, so all toast is served hot, fresh, and crisp.

TRY PUTTING A "Toastmaster"* Toaster on diet-kitchen duty. You'll be happy with its completely automatic operation, the time and steps it saves, the sturdiness of its construction, the ease with which it can be kept clean. And how your patients will appreciate the perfect toast—the hot, fresh, delicious toast you serve! Call your food-service equipment dealer, today.

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therefore, the use of dextrose as a portion of the total sugars can give better color to such foods as ketchup, preserves, pickled beets and fresh cucumber pickles, all of which are heat-processed under acid conditions.

A new standard of identity for bread to be established by the Food and Drug Administration has been delayed by the controversy over the use of emulsifiers or so-called "bread softeners."(61) Shortening manufacturers have objected to the inclusion of such materials as polyoxyethelene monostearate on grounds that the use of emulsifiers replaces part or all of the fat, oil and milk content and lowers the nutritive value of the products, undermines the marketing of lard and other shortenings, and presents a question of toxicity.(61,62) The effect on anti-staling of bread was reported to be the same as that of monoglyceride shortening but to a greater degree. A comparison of bread and cakes using emulsifiers, lards and hydrogenated shortening containing monoglycerides and diglycerides resulted in no differences in external appearance but varied markedly in crumb texture, tenderness and palatability in favor of those containing lard and shortening; in cost, emulsifiers won out.

The possibility that agene, nitrogen trichloride, might be toxic to human beings was partly responsible for its use being declared illegal as a maturing agent for white flour. Although it has been shown to produce running fits in dogs, rabbits, cats, mink and ferrets, large quantities of agenized flour fed to rats, chicks or guinea pigs did not result in their developing fits. The possibility that agenized flour might be a cause of human epilepsy inspired a study in which 19 patients, including five with epilepsy, were fed a diet containing 22 to 30 times the amount of agenized material contained in a normal diet. Physical, neurological and electroencephalographic examinations failed to disclose any abnormal changes, and none of the patients developed epileptic seizures as a result of such a diet.(63)

A new bread formula using soy flour and dry milk was perfected at the request of the New York State Department of Mental Hygiene. Since a survey showed that patients in their state institutions were making bread the main portion of the meal, the development of a better bread became a focal point. Calories and carbohydrates were reduced while protein, calcium, phosphorous, iron and riboflavin content was increased. The new formula provides equally available protein at one-fifth the cost of serving it in meats. Owing to the high percentage of non-fat dry milk solids as well as soy flour, the bread colors quickly and too much moisture should not be applied or the resulting crust will be tough and have a "foxy red" color.(64)

In a study of factors influencing the beading and leakage of soft meringues,(65) undercooking proved to be responsible for excessive leakage and was brought about by baking meringue on a cold base (about 59° F.) or baking the meringue a short time at a high temperature. Observations on time and temperature of baking indicated that the length of time a meringue is held at a temperature within coagulation range is more important in minimizing leakage than is the maximal internal temperature reached. Beading, on the other hand, was found when conditions brought about overcoagulation such as those when meringues were baked on a hot base (about 140°F.) or baked too long at a low or moderate oven temperature.

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What Makes a Modern Kitchen

ALEXANDER BERESNIAKOFF
Architect, New York City

THE kitchen is the most important area in a hospital. No matter how skillful the surgeon may be, no matter how good the medical specialist is, no matter how efficient the nursing service, and no matter how expensive and extensive the diagnostic and therapeutic facilities, the patient will not get well without good nourishing food carefully prepared and palatably served. Therefore, everyone connected with the kitchen, from the trained dietitian to the attendant carting the food truck, contributes immeasurably to the efforts of the medical, nursing and technical personnel to bring the patient back to health.

In order to prepare good food to meet all the dietary needs, and to get this food to the patients, a hospital must have a good working kitchen and efficient personnel. A good working kitchen is one that is well planned, and an efficient personnel finds all the means for its work properly provided and methodically arranged.

The primary requisite for a good working kitchen is ample natural light and ample space. It used to be the custom to locate the kitchen in the basement of the hospital, the least desirable location for any other function, and with just enough space to squeeze in the equipment, with little regard for the needs and comfort of the people working there. This, however, is no longer the case.

Light, airy, roomy, comfortable kitchens are practically the slogan now, and credit for this is due to the present-day dietitians who know that to get the best results out of the personnel under their jurisdiction it is essential for this personnel to work in kitchens which do not require artificial light throughout the day and are not so hot as to cause constant perspiration and discomfort.

As regards location, size, equipment and working comfort, modern hospital kitchens receive the same consideration that is given operating rooms or other departments of similar importance. The first floor, on the same level as that on which the provisions are received and stored, is the preferred location, provided, of course, there are no obstructions of any kind to prevent an abundance of natural light and ventilation. In many instances, however, kitchens have been and are being located on the top floor in order to achieve the greatest amount of window area and on more than one wall of the room.

The equipment in the present-day hospital kitchens is as modern as the ingenuity of man can devise. All of it, from the heavy duty ranges and kettles to the sinks where the employes wash their hands, is constructed of materials that ensure the utmost cleanliness. Also the walls and floors are of materials which can be kept clean with a minimum amount of scrubbing.

HELPS PATIENTS TO RECOVER

In addition to the maximum of windows, mechanical ventilation is also provided. Thus, the kitchen is a clean, comfortable, practically odorless place in which to work, and the food prepared in such kitchens by satisfied, competent personnel becomes a great factor in the work of the surgeon, medical man, technician and nurse in their efforts to restore the patients to normal health.

The foregoing may apply to a central kitchen, in which all the food is prepared, and from there moved in food carts (insulated or electrically heated) to the various floors of the hospital. Some hospitals are abandoning the central kitchen system, and are adopting decentralized kitchens found in the newer installation. These kitchens are located on every patients' floor and are completely equipped to prepare all the food for the patients on that floor only, thereby assuring greater selectivity and much quicker service from the range to the bedside.

These kitchens, too, are planned for abundance of light and ventilation and are provided with gleaming equipment. They have everything to make them ideal places in which to work, under conditions providing the utmost cleanliness and dispatch in the preparation of the food, and also in getting it to the patients hot and palatable.

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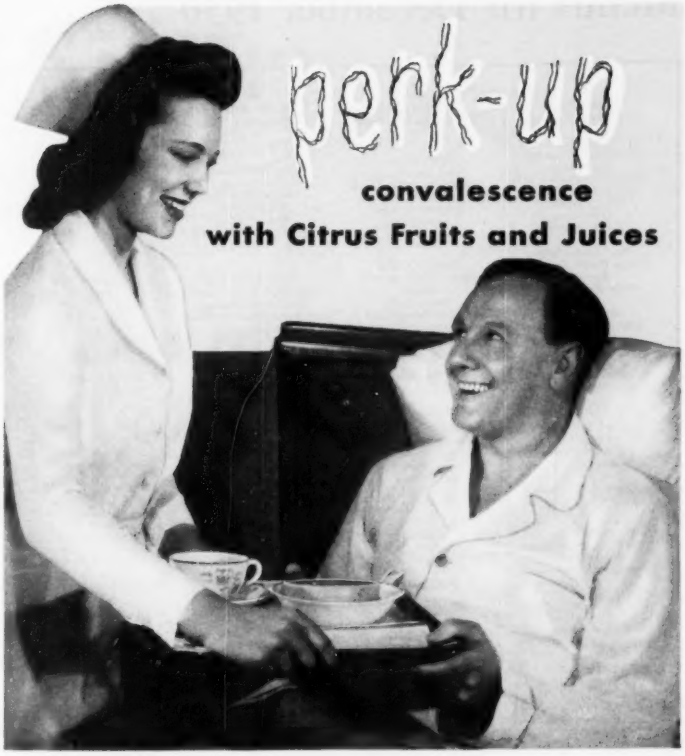
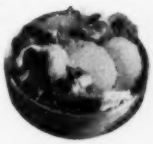


"Citrus fruits are among the richest known sources of vitamin C. They also contain vitamins A, B_1, and P, and readily assimilable natural fruit sugars, together with other factors such as iron, calcium, citrates and citric acid.

The eye- and appetite-appeal of colorful citrus fruit cups and salads can go far to stimulate the often indifferent interest of the convalescent in his diet. Lavishly endowed by nature with a wide variety of nutrients*—including an exceptionally high vitamin C content and easily assimilated fruit sugars[2] for quick energy release—citrus fruits and juices can help significantly in improving appetite,[3] promoting mild laxation[1] and systemic alkalinization,[3] and in bettering calcium utilization.[3] They are particularly beneficial in the management of chronic infectious conditions.[1] Florida citrus fruits and juices are convenient to use, low in cost, relished by patients of all ages—whether fresh, canned, concentrated or frozen.



FLORIDA CITRUS COMMISSION • LAKELAND, FLORIDA

FLORIDA *Oranges Grapefruit Tangerines*

References:

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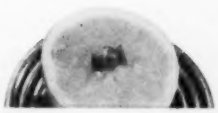
2. McLester, J. S.: Nutrition and Diet, Saunders, Philadelphia, 4th ed., 1944.
3. Rose, M. S.: Rose's Foundation of Nutrition, rev. by MacLeod and Taylor, Macmillan, 4th ed., 1944.



Menus for December 1950

Maude Battle Jacobsen
Los Alamos Medical Center
Los Alamos, N.M.

1 Stewed Prunes Cinnamon Roll, Bacon • Tomato Soup Casserole of Tuna and Mushrooms Candied Sweet Potatoes Buttered Green Beans Celery, Radishes, Cucumbers Frozen Peaches • Beef Noodle Soup Cottage Cheese Croquettes, Egg Sauce Fresh Minted Glazed Carrots Potato Salad Cake With Fruit Sauce	**2** Grapefruit Juice Soft Cooked Egg, Toast • Corn Chowder Roast Leg of Lamb Boiled Rice, Brown Gravy Creamed Peas Fresh Fruit Salad Brownies • Vegetable Soup Baked Macaroni and Cheese Savory Beets Tossed Green Salad Caramel Ice Cream	**3** Seedless Grapes Cheese Omelet, Toast • Pineapple Juice Prime Rib Roast Mashed Potatoes Baked Spinach Waldorf Salad Bread Custard Pudding • French Onion Soup Ham Loaf, Raisin Sauce Escalloped Tomatoes Asparagus, Pimiento Salad Cherry Pan Pie	**4** Sliced Oranges French Toast, Jelly • Cream of Celery Soup Grilled Liver Onion Rings Paprika Potatoes Peach, Cottage Cheese Salad Raspberry Ice Cream • Split Pea Soup Beef Pie Baked Stuffed Potato Chinese Salad Fresh Fruit Cup	**5** Stewed Apricots Bran Muffins, Bacon • Creole Soup Baked Chicken, Dressing Buttered Corn Toasted Carrots Cranberry Salad Filled Oatmeal Cookies • Savory Potato Soup Shrimp Creole Boiled Rice Pick-up-Stick Salad Date Nut Pudding	**6** Blended Fruit Juices Scrambled Eggs • Chicken Rice Soup Stuffed Pork Chops Mashed Sweet Potatoes With Raisins Buttered Cabbage Sliced Tomato Salad Apple Crisp • Cream of Asparagus Soup Beef Patties, Spanish Sauce Baked Cubed Potatoes Lettuce Wedges Cherry Gelatin, Custard Sauce
7 Pink Grapefruit Poached Eggs, Toast • Black Bean Soup Veal Steaks Cubed Potatoes Beets With Orange Sauce Lettuce Wedges Glazed Baked Apples • Tomato Okra Soup Beef Loaf, Brown Gravy Escalloped Corn Cucumber Lime Salad Fruit Bars	**8** Tangerines Soft Cooked Eggs • Creamed Onion Soup Baked Halibut Fillet, Lemon Butter Sauce Parslied Potatoes Creole Green Beans Carrot Sticks, Pickles, Celery Lemon Meringue Pie • Oyster Stew Escalloped Potatoes Buttered Broccoli Tossed Green Salad Chocolate Ice Cream	**9** Sliced Bananas Cinnamon Toast, Bacon • Cream of Mushroom Soup Roast Fresh Ham Snowflake Potatoes Glazed Parsnips Sliced Tomato Salad Devils Food Cake • Consommé Baked Tuna and Noodles French Fried Onions Buttered Peas Waldorf Salad Spanish Cream	**10** Frozen Orange Juice Coddled Eggs, Bacon • Cream of Pea Soup Lamb Chops, Mint Jelly Candied Sweet Potatoes Green Lima Beans Chopped Vegetable Salad Chocolate Pudding • Potato Soup Stuffed Beef Heart Creamed Red Cabbage Molded Carrot, Pineapple Salad Strawberry Ice Cream	**11** Fresh Pears Soft Cooked Eggs, Bacon • Tomato Rice Soup Chicken Fricassee Mashed Potatoes Asparagus Tips Perfection Salad Fruit Cocktail • Corn Chowder Salisbury Steak Hashed Browned Potatoes Sliced Lettuce Salad Chocolate Gingerbread	**12** Blended Fruit Juice Omelet, Jelly • Beef Broth Roast Pork, Gravy Buttered Noodles String Beans Boheme Radishes, Olives, Cucumbers Apricot Whip • Chicken Noodle Soup Grilled Cheese Sandwich Stewed Tomatoes Potato Salad Apple Pan Pie
13 Prune Juice Poached Eggs, Muffins • Tomato Bouillon Veal Birds Corn Pudding Creamed Peas Orange Waldorf Salad Peanut Cookies • Cream of Asparagus Soup Chicken Noodle Casserole Baked Acorn Squash Red Cabbage Slaw Chocolate Peppermint Roll	**14** Half Grapefruit French Toast, Honey • Cream of Pea Soup Broiled Steak Shoe String Potatoes Carrots à la King Tomato Aspic Iced Sponge Cake • Celery Soup Beef Loaf, Horseradish Sauce Brown Rice Mixed Green Salad Frozen Raspberries	**15** Stewed Peaches Soft Cooked Eggs • Cream of Tomato Soup Sautéed Perch Snowflake Potatoes Asparagus Spears Grapefruit, Orange Salad Applesauce Cake • Creole Soup Escalloped Oysters Buttered Whole String Beans Lettuce Wedges Lemon Meringue Pudding	**16** Sliced Bananas Scrambled Eggs, Toast • Consommé Roast Beef Mashed Potatoes Harvard Beets Chopped Vegetable Salad Coconut Citrus Fruit Cup • Vegetable Soup Ham, Spaghetti Casserole Fresh Minted Glazed Carrots Complexion Salad Apricot Pudding	**17** Pineapple Juice Cinnamon Rolls, Bacon • Corn Chowder Roast Turkey, Giblet Gravy Sage Dressing Baked Spinach With Sliced Eggs Golden Pineapple Salad Angel Food Cake • Vegetable Bouillon Baked Ribs, Barbecue Sauce Stuffed Potatoes Sliced Tomato Salad Prune Plums	**18** Tangerines Egg Omelet, Jelly • Cream of Mushroom Soup Roast Leg of Lamb Potatoes au Gratin Buttered Peas Under the Sea Salad Orange Cup Cakes • Turkey Rice Soup Creamed Chipped Beef Baked Potatoes Tossed Green Salad Glazed Baked Apple
19 Frozen Orange Juice Bacon, Muffins, Jelly • Savory Celery Soup Country Fried Steak Mashed Potatoes Buttered Cabbage Sliced Tomato Salad Chocolate Meringue Pudding • Beef Noodle Soup Salmon Croquettes, Egg Sauce Parslied Potatoes Buttered Asparagus Pick-up-Stick Salad Peach Pan Pie	**20** Stewed Apples Baked Egg, Jam • Consommé Beef Pot Roast Steamed Potatoes Glazed Onions Tossed Lettuce, Spinach Endive Salad Pumpkin Chiffon Pie • Cream of Tomato Soup Grilled Ham Creamed Potatoes Carrot Pudding Cranberry Salad Peppermint Ice Cream	**21** Grapefruit Half Sweet Rolls, Bacon • Vegetable Soup Roast Pork, Gravy Candied Sweet Potatoes French Cut Green Beans Carrot Sticks, Sliced Cucumbers Baked Custard • Oyster Stew Italian Spaghetti Meat Balls Buttered Peas Chopped Lettuce, Olive Salad Fresh Fruit	**22** Pineapple Juice Scrambled Eggs • Celery Soup Salmon Steaks Baked Stuffed Potatoes Creamed Asparagus Tomato Wedges Orange Cake • French Onion Soup Toasted Cheese Sandwich Mashed Potatoes Cabbage Slaw Prune Whip	**23** Sliced Orange Bran Muffins, Jelly • Fish Chowder Roast Veal, Brown Gravy Spanish Rice Broccoli Peach Salad Chocolate Ice Cream • Cream of Asparagus Soup Broiled Beef Patties Mexican Kidney Beans Tossed Green Salad Banana Cream Pie	**24** Prune Juice Soft Cooked Egg, Bacon • Tomato Soup Baked Fresh Ham O'Brien Potatoes Mustard Greens Pear Grated Cheese Salad Orange Tapioca Pudding • Cream of Mushroom Soup Tuna Noodle Casserole Buttered Whole Green Beans Wilted Lettuce Salad Angel Food Cake
25 Tangerine French Toast, Sirup • Chilled Apple Juice Roast Turkey, Giblet Gravy Cranberry Sauce Mashed Sweet Potatoes With Marshmallows Brussels Sprouts Celery, Olives, Pickles Molded Cherry Pineapple Salad Christmas Fruit Cake • Cream of Lima Bean Soup Stuffed Pepper, Tomato Sauce Oven Browned Potatoes Cabbage Carrot Salad Eggnog Ice Cream	**26** Canned Figs Orange Muffins • Turkey Rice Soup Stuffed Pork Chops Whole Kernel Corn Buttered Cauliflower Tomato Salad Christmas Cookies • Vegetable Soup Meat Croquettes, Parsley Sauce Escalloped Potatoes Asparagus Pimiento Salad Raisin Pie	**27** Sliced Bananas Poached Eggs • Split Pea Soup Roast Shoulder of Lamb Steamed Rice, Gravy Buttered Green Beans Cranberry Salad Date Nut Bars • Onion Soup Beef Stew With Vegetables Tossed Green Salad Cake With Frozen Strawberry Sauce	**28** Grapefruit Orange Juice Cinnamon Toast, Bacon • Pepper Pot Soup Swiss Steak Mashed Potatoes Buttered Peas Peach and Cottage Cheese Salad Gingerbread, Lemon Sauce • Consommé Creamed Chicken Toasted Baked Potatoes Red Cabbage Slaw Sliced Pineapple	**29** Stewed Apricots Coddled Eggs • Citrus Fruit Cocktail Fried Scallops Snowflake Potatoes Breaded Tomatoes Celery Hearts Iced Cup Cakes • Potato Soup Creamed Tuna on Toasted Buns Succotash Lime Sherbet, Cookies	**30** Grapefruit Sections Scrambled Eggs, Jelly • Savory Potato Soup Grilled Ham, Fruit Sauce Corn Pudding Baked Cinnamon Acorn Squash Perfection Salad Prune Plums • Chicken Rice Soup Braised Beef Steamed Potatoes Carrot, Raisin Salad Chocolate Peppermint Roll

31 Frozen Orange Juice, Date Muffins, Bacon • Beef Bouillon, Veal Chops, Candied Sweet Potatoes, Buttered Spinach, Tomato Salad, Pecan Ice Cream • Oyster Bisque, Beef Biscuit Roll, Brown Gravy, Creamed Peas, Pear-Grated Cheese Salad, Iced Sponge Cake

Ready-to-eat or cooked cereals are offered on all breakfast menus.

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in every kind of kitchen...

Ac'cent heightens and holds fine food flavors

...makes good cooking taste better!

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1. Add 1 oz. Ac'cent per 5 gallons of soup, chowder or purée. Broths and consommés require slightly less; heavy cream soups, a little more.

2. Sprinkle Ac'cent on hamburgers, steaks, chops and fish *prior* to frying or broiling. Proportion should be 1 oz. Ac'cent per 25 lbs. meat, fish.

3. In stews, both meat *and* vegetables should be seasoned with Ac'cent. Use Ac'cent in sauce, also. Add 1 oz. Ac'cent to each 5 gallons of stew.

4. For roasts and other solid cuts of meat, season with Ac'cent by adding it to gravy or sauce at the rate of about 1 oz. per gallon.

5. For vegetables, add 1 oz. Ac'cent per 30 lbs. Ac'cent should be sprinkled on when vegetables are seasoned and placed in steam table.

6. Season your salad dressings with Ac'cent. Use about 1 oz. Ac'cent in each 5 gallons.

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CONDUCTIVE FLOORING reduces the hazard of anesthetic gas explosions

DEAN S. HUBBELL
Senior Fellow
Mellon Institute
of Industrial Research
University of Pittsburgh
Pittsburgh

THE hazard of explosion during the administration of an inhalation anesthetic can now be largely eliminated as the result of a better understanding of its cause, and of the means of reducing or eliminating static sparks in the hazardous area. Recently, two groups of specialists—the Government Interdepartmental Committee on Explosions in Hospital Operating Suites and the Committee on Hospital Operating Rooms of the National Fire Protection Association — have published standards that are the product of considerable study and deliberation.

The language of any standard makes dull reading, and it is sometimes difficult for those in other fields to get a clear picture of the problem and the intent of the recommendations. Believing that it might be helpful to explain some of the "whys and wherefores" behind the recommendations of the interdepartmental committee and the N.F.P.A., I offer the following paragraphs. It is hoped that this obvious over-simplification of the problem will not be construed as covering each of the multitude of problems that have been considered by the committee.

PROVIDE PATH FOR STATIC

A spark occurs only as the last resort in the effort of electrostatic charges to neutralize themselves. Therefore, we shall have gone a long way toward eliminating electrostatic sparks, and the explosions resulting therefrom, if we provide an adequate path for the travel of static between all personnel and furnishings and equipment in an operating room.

Inasmuch as practically everything in the hazardous lower portion of the room rests on the floor, it can serve as the most convenient common path for the equalization of static charges that might be generated in the suite or brought to it on insulated portable equipment or personnel.

At first thought, a metal floor would appear to be the best insurance that everything in contact with it would remain at the same potential. However, such a floor, or one in which metal strips are exposed on the surface, introduces the hazard of shock or spark from the grounding of the hot side of lighting or power circuits. Because one side of conventional circuits is grounded, the current supplied to electric lights and appliances is seeking a path to ground, and for this reason no thoughtful person would replace a bulb or would handle (carelessly) an electrical appliance when standing on a good "ground" or sitting in a bathtub.

It has been suggested that this danger could be avoided if the exposed metal on the floor were grounded only through a fixed high resistance. This idea has been discarded because, practically, there are too many ways in which the floor could become grounded inadvertently — through other paths, such as water, drain and heating pipes. A pail or stool or even a pool of water could bridge between such ground conductors and the exposed metal in the floor and thus avoid the planned high resistance path. A person with low resistance shoes standing at a sink could provide a bridge between the floor and ground. A second person might conceivably become a low resistance bridge between the floor and a faulty appliance. The result would be a shock for both persons.

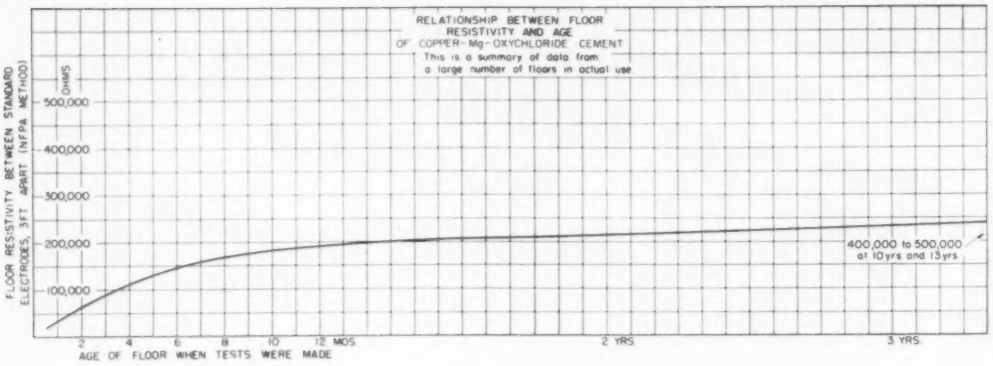
The use of ungrounded circuits as provided by isolation transformers on all circuits supplying the suite would reduce the hazard materially. Such installation in existing buildings is costly and often difficult.

Obviously, a floor system that consists of extremely high resistance areas crisscrossed by metal strips involves two objectionable conditions: insufficient conductivity in the areas and excessive conductivity in the strips.

There is another and simpler way to equalize static potentials without incurring hazards from electrical circuits. Static charges will leak away quickly through materials that have sufficiently high resistance to prevent them from carrying dangerous amounts of current from lighting and power circuits. Although static voltages are high, the actual quantity of energy involved is quite small.

COULD CAUSE HOT SPARK

For example, suppose a wool blanket were grasped in both hands and drawn rapidly over the surface of an operating table and completely off the edge. If the table were isolated, it would acquire a charge as great as 10,000 volts. The actual quantity involved (voltage x capacitance of the table) would be about 3 microcoulombs. This amount is ample to cause a hot spark if it is forced to jump to ground or another capacity at lower potential. It will, however, be instantly dissipated through a megohm path. If, for example, the table is properly grounded to a floor that meets the specified conductivity, the charge on the table will be instantly shared with the floor and with everything in proper contact with it, each in proportion to its capacitance. Inasmuch as the total capacitance would be thousands of times greater than that of the table, the voltage would immediately drop to a negligible amount.



Consider the analogous case of water pressure. The amount of energy (3 microcoulombs) represented by the static charge on the table is equivalent to the potential energy stored in a column of water 4 feet high and the diameter of the lead in an ordinary pencil. Although the collapse of such a column would cause a splash, it would not constitute much of a flood threat since only 62 drops of water are involved. If this water was spread evenly over a large area instead of being piled up, it could no longer make a splash, in fact, could scarcely dampen the surface.

Returning to the subject of static, the charge so distributed to the floor could not be built up by any procedure that is possible in an operating suite, for the leakage to the air and through the multitudinous paths in the building structure is too great. You can't fill a barrel if there is a hole near the bottom that is many times the size of the entering stream. For these reasons it is not required that floors must be deliberately "grounded."

It is generally agreed among workers in this country and abroad that a megohm is probably the most desirable resistance in the total path between objects or personnel or between them and earth, although a 5 or 10 megohm path is still sufficiently conductive for safety. It is probable, however, that there are other resistances in the path, such as through the shoes, resistance of the contact to the floor, and so on. Therefore, to allow for these contingencies, an upper limit of a half megohm has been established for the floor itself (measured between standard electrodes, 3 feet apart). The lower limit has been determined simply as one that will not permit a dangerous amount of current to flow from an accidental grounding of power and lighting circuits as discussed in an earlier paragraph. This value has been set at 25,000 ohms. Such a resistance would permit about 5 milliamperes to flow from a defective wire or appliance (not enough to produce a visible spark). If a person should inadvertently touch a "hot side" while standing on the floor or in contact with a table or stool that rested on the floor, his resistance of approximately 10,000 ohms would be added to the 25,000 ohms and he would receive approximately 3.5 milliamperes. This would be felt but would not be serious. Ten milliamperes appears to be the level where shocks begin to cause cramping of the wrist muscles.

Although the specified range in resistance (25,000 to 500,000 ohms) seems large numerically, it is actually quite small as compared with the spread between "conductive" and "insulative" materials. This is shown by the following tabulation (expressed in ohms):

	OHMS
Metals (practically)	0
Specified Range: Lower limit	25,000
Specified Range: Upper limit	500,000
Wood (maple)	2,000,000,000
Marble	10,000,000,000
Unglazed ceramic tile	30,000,000,000,000
Rubber	15,000,000,000,000,000

In addition to describing the apparatus and procedure to be used in measuring resistance, the standards require that the tests shall be conducted *on the floor*. This is because it is only after a floor has become an integral part of the structure that measurements of resistance are significant. It follows, therefore, that only after a floor has been installed and has reached equilibrium with its environment can it be tested and approved. Perhaps the best assurance, aside from the integrity of the supplier, that a proposed floor will meet the standards is the record of performance over the years of a large number of floors of the same material under similar—or more severe—conditions of use.

There are at least two classes of materials that can be designed to fall within this range of floor resistance while meeting other architectural requirements of a floor surface. One is produced by adding certain conductive ingredients to a commonly used floor surfacing material. The conductance of the other derives from the electrically conductive nature of the cementing ingredient. Floors of this second type do not require the addition of conductive materials; but, obviously, if their conductance is to persist after frequent washing, the constituents upon which it depends must not be soluble in water, as is the case in some plastically applied floor surfaces.

In the case of a floor surfacing material with which I am familiar, the cementing ingredient is an insoluble copper-magnesium oxychloride which, by happy coincidence, has the correct amount of conductance. Since it is not soluble in water, it assures that the floor will remain within the specified limits even after years of scrubbing. The accompanying curve summarizes the data gathered from floors tested under a variety of conditions and at all ages up to 10 years and more (including 4 to 5 million square feet in smokeless powder plants). This is offered as evidence that an architecturally desirable floor can also meet—and continue to meet—the limits of resistance set by the new standards.

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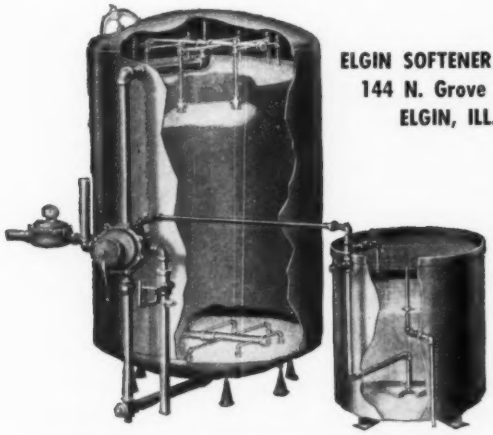
Despite the fact that every hospital management seeks these results beyond all others, there are still hospitals that do not have a water softener, or that have an inadequate softener which limits the use of soft water to the laundry alone, thus passing up dollar-saving benefits in other departments.

If your hospital falls into either of these classes, the Elgin "Double Check" Softener can make real profits for you. It will do this by giving you up to 44% more soft water from a given size softener—by giving you all the soft water you need without a premium price.

Yes, all the zero-soft water you need! Not just enough for the laundry but enough for boiler-feed, hot water systems, cleaning and all other services. It will pay its way and then some in soap savings, in longer life of linens, in freedom from boiler cleanings and repairs, in easier, better cleaning of the building, in increased life of piping and sterilizers, instruments and equipment, in speeded dish-washing, in that big end-result: greater prestige and patronage.

Note operation of Elgin "Double Check" Softener explained opposite.

Write for Bulletin 608—twenty pages of interesting facts about soft water for hospitals.



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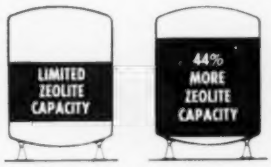

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The diagrams above show why the Elgin "Double Check" Softener gives 44% more soft water—from the same identical softener using the same identical zeolite. The Elgin "Double Check" manifold system does the trick — prevents costly escape of zeolite; permits the use of far more zeolite, the mineral that does the softening. The Elgin method also permits a high back-wash rate that means better regeneration from less salt.

Also adaptable to your present softener

In hundreds of plants we have stepped up the delivery of soft water by equipping existing softeners (any make) with Elgin "Double Check" Manifolds. Cost is low; here is how it figured out in one case: manifolds, $130.00; added zeolite, $71.00. Soft water generation was stepped up to that of a new $1200.00 softener. There's an easy way to make a thousand dollars! Our district engineer will be glad to explain this.

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ECONOMICAL WATER CONDITIONING
SINCE 1908

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Conducted by Alta M. La Belle and Jane Barton

TIME and MOTION STUDIES

increase efficiency and reduce worker fatigue

SANFORD E. MAUS, C.P.A.
Partner of
Harris, Kerr, Forster & Company
New York City

TIME and motion studies have long been an important tool of industry. We in the institutional field are not as familiar with them because of the multiplicity of problems which do not fall into a straight routine process and have produced a feeling in many quarters that industrial methods are not applicable to the institutional field. This is a false observation and many of our larger institutions, particularly hotels, are stressing and making ever increasing applications of industrial methods.

When I attempt to define time and motion, I am always reminded of what seems to me an almost perfect example. How many of you have ever watched a typical suburban commuter or have thought of the planning, timing and motion economy that goes into the process between the time he leaves his bed and the time he arrives at his place of business?

HE HAS IT ALL FIGURED OUT

When he sets the alarm clock at night, he mentally provides for his time of arising, for time to shave, take a shower, dress, perhaps eat breakfast. He then allows so much time to get to the corner to the bus or to walk to the station. If you watch this creature carefully, you will find he has computed down almost to the second the length of time it takes to shave. This is the time element of his operation. If he finds the time element is too long, he will experiment with ways he can take the beard off a little faster. This is motion economy which results in a time saving. When he leaves the house, he has every vacant lot figured out so that by cutting across he can eliminate so many steps and conversely so much time in getting to the station. He enters the station at the point that is most convenient to reach the platform with the fewest steps and still enable him to buy his paper. He carefully plans his position on the platform in order that he may take advantage of the spot in which he thinks the doors of the train will be located when it stops. This avoids unnecessary jostling through the crowds and saves him time in getting to his seat on the train.

This may be a homely illustration but it contains truly enough the primary elements of time and motion worked out to perfection by an individual who has a prime incentive to work it out to the full, namely, his own selfish interests and creature comforts.

Institutional operations are not widely different from those of the suburban commuter. There are only so many hours in the day and so much work that must be done. Accordingly, if we reduce each operation to a minimum time expenditure and eliminate a majority of the lost motion we should be able to improve our production quotas for the day.

If we use the suburban commuter as an example, it might be interesting to watch him once he enters his place of work. I'm afraid we would all too often find that he completely loses that keen sense of planning, time conservation, and elimination of lost motion which characterized his process in actually getting to work. We might find that he becomes only a partially efficient person in his daily routine. Let us ask ourselves why this is.

A goodly portion of the reason for a worker's loss of efficiency must lie with management itself. Basically, people learn by doing and they learn certain routines by a process of habit. This is particularly true when we work with a group that has a limited educational background such as we often find among institutional employes. In other words, the work habits of the individual concerned will be good or bad depending upon the early basic training and the follow-up training that have been afforded him during the process of his working life. What then is the obligation of management toward this worker from the standpoint of helping him to do a better job?

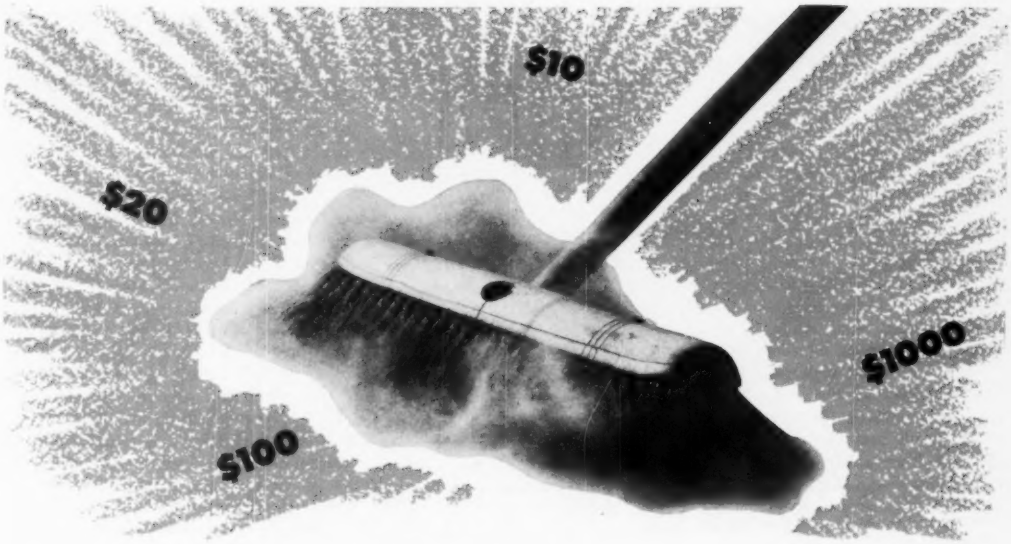
NOT A QUESTION OF "SPEED-UP"

The basic concept of time and motion studies is not a question of sheer "speed-up." Unfortunately, it has been associated historically with certain speed-up plans which tended to ignore the basic rights of the worker and therefore has established a bad connotation in many people's minds.

When we talk of time and motion study, we should rightfully separate the two aspects of the problem for thorough analysis. Time study refers to a detailed study of the actual time consumed in the performance of any given operation, or series of operations, which the worker may perform in the course of his daily work. This element of the study does not concern itself immediately with whether the task is being performed efficiently or not but rather is an evaluation of the productive performance of the worker himself.

Once we know the timing of an operation, the process of motion study enters the picture. In motion study the analyst breaks down the present

Condensed from a paper presented at the biennial congress of the National Executive Housekeepers Association, June 1950.



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12

method used into each of the separate elements concerned in doing the total job in order to determine whether or not there is an easier method of accomplishing the same objective.

Someone might logically ask the question: After we go through all of the rigamarole, what benefit do we derive? The procedure has a genuine value both to management and to the employe. From the standpoint of the employer it seeks to provide a maximum output of standard quality work at a minimum cost per unit. For the employe, modern time methods seek to provide maximum earnings commensurate with effort expended. They further seek methods that will accomplish this by making the work processes as simple and easy to perform as possible. They aim at the elimination of lost motion and the consequent fatigue that must accompany it. However, wisely conceived, improvements sought through the medium of time and motion studies do not attempt to pile a greater burden of work on the employe. They seek, if anything, to take work away so that the employe can produce the same end result with a minimum of peak load rush and fatigue.

TWO HANDS WORK BEST

The time study engineer in his analysis of the methods used in doing any job asks himself several questions and studies many aspects of the operation. It has been found that simultaneous and rhythmic motion of both hands will often double the work which a person can accomplish without imposing any burden of fatigue. Actually, it is much simpler to do a task when the hands are engaged in the same motion than it is when the applications differ at any given time. He further seeks to discover the simplest method of grasping, holding or releasing an object. He seeks to eliminate the mental diversions caused by an employe's having to search for or select an object before he can complete his task. When these answers have been accumulated, the engineer is then in a position to rebuild the cycle of functions involved in the completed task to simplify its application.

So much for the pure theory of time and motion study. Let us take a few examples of the application in actual housekeeping tasks and see how the foregoing principles apply.

Perhaps the best examples of time and motion study applied to housekeeping are the extensive studies of bedmaking. Our firm has made many studies in the field of housekeeping and in each instance the physical task of changing and making the bed bulks as an important time consumer in the over-all cleaning process.

No doubt a great many of you read with interest the articles that were published a year or two ago in one of the leading weekly magazines which showed the typical motions involved in making a bed by an average housewife or maid. They then illustrated the method of making a bed with the fewest possible motions and the results were astonishing. Unfortunately, we find in our studies that this method has not been adopted in any appreciable scale in institutional operation. Again, we go back to that primary concept of training, where the task of converting old-time maids to new methods has been probably given up in despair.

Under the method used, it was shown that it was possible to start at one of the upper corners and, by moving once around the bed, every operation concerned in the changing and making of the bed should be accomplished. Are some of you skeptical? I was, too. But I have found by experimenting myself that the method is definitely feasible and, furthermore, will cut the time required to make a bed from 20 to 25 per cent. This does not seem like much but if we consider that making a bed may take from 5 to 5½ minutes, a time saving of 20 per cent means one minute per bed. If an average maid assignment of 15 to 18 rooms includes 20 to 22 beds, we have an aggregate saving of 20 to 22 minutes over the maid's day. This means a certain amount of additional time which might be applied to another task. If kept up on a daily basis, the added effort might cut down our later heavy cleaning work.

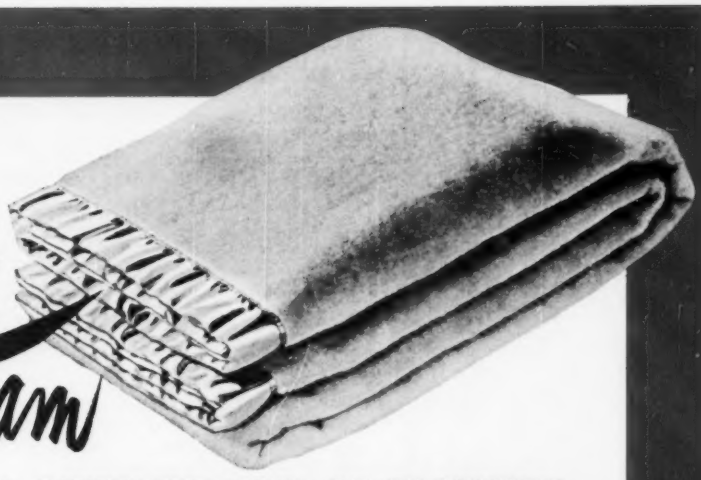
Furthermore, this represents merely one task in the over-all process of cleaning a room. Studies over a certain number of hotel rooms have been shown to require some 25 to 30 minutes for a typical room. Twenty per cent saved on the over-all process would represent six minutes per room or an hour and a quarter to an hour and a half per day based on a minimum of 15 rooms.

In time and motion study the analyst asks himself or the supervisor the reason for each particular operation. In one hotel we made a series of studies of the maid's work. It was found that an average of a minute and a half of the maid's time per room was consumed in cleaning the dresser and removing spots from the mirror. In addition, she had to dust a chest of drawers, a vanity dresser and combination desk. This led to a long consideration of the actual value of the dresser in view of the extensive drawer space which was available in the chest of drawers. After many tests, it was decided that the dresser itself was not necessary inasmuch as adequate mirror space was provided otherwise and the drawer space was not used often enough to make it practical to maintain this particular piece of furniture. The removal of this piece from the various guest rooms not only saved a minute and a half per room of each maid's time, but also meant one less piece of furniture for the vacuum man to move.

PRODUCTIVE TIME TOO LOW

We recently made a study of a large and well operated hospital. From the standpoint of housekeeping I would class this institution as immaculate. However, the management was concerned with whether the cost of its various functions was excessive. As one point in answering this question, we made a detailed time study of the floor maids. A casual observation prior to the time study had indicated that the maids' days were fully occupied and that there was little, if any, opportunity for readjustment of their work schedules. However, the searching scrutiny of the time and motion study revealed some interesting facts. First of all, it was found that over the complete eight-hour shift, the average productive time spent by these employes amounted to less than six hours of actual required work.

While we know it is impossible to expect 100 per cent productivity from any employe, nevertheless, the actual production in this instance was appreciably below standard. You may ask



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why with competent supervision this was not discovered. As I stated, casual observation would indicate that the chamber maids were fully occupied. However, we found that day after day one particular maid spent approximately one hour's time folding 100 napkins, on an average, during this period. This was purely fill-in work to occupy her time, and without a detailed check of the production, no one would ever know whether she folded a hundred or a thousand paper napkins within this period.

As a result of these studies, the work schedules were rearranged with a substantial saving in manpower. Certain related suggestions as to procedures produced the end result that despite a curtailment of staff the individual maids did not have to work any harder than they did formerly.

We could go on endlessly citing examples of how time study operations have proved of benefit not only in the housekeeping functions of hotels, hospitals and other institutions but also in other departments in other types of businesses. Granted the very nature of institutional operation does not lend itself as readily as does the straight mechanics of an assembly line in a factory, yet every task has its component parts and the principles of time and motion study apply just as readily here as they do in a manufacturing operation. It is the basis of establishing proper standards of performance and staff scheduling.

The representatives of labor have in many ways been more forward thinking than management has. As a result, they are probably in a better position to work toward the ultimate goal of a close cooperative working relationship between management and labor, which every industry must ultimately achieve if it is to be operated for the best interests of all concerned. Those who represent management must therefore make sure that they are in an equally advantageous position, that they know the detailed facts of their operation not purely from the standpoint of long-range experience but also from an intimate study and knowledge of the details. Furthermore, we owe it to our employes to afford them the best working methods, tools and supervisory guidance that it is in our power to give. The fact has been developed in many surveys designed to discover the reason for labor turnover that one of the primary complaints of the subordinate worker is that his supervisor does not have sufficient interest in him and what he is doing. This has actually accounted for more employe terminations than the question of either pay or actual working conditions.

SHOULD SERVE AS ADVISER

Another important function of the executive housekeeper is her capacity as an adviser to management both in rehabilitation projects and in new construction. Management is constantly seeking new means of constructing and designing physical facilities in order to create a more efficient operation. Who should be in a better position to advise on the importance of various designs of guest or patient rooms than the housekeeper who should intimately understand the details of the work load as it is influenced by the physical design of the facilities?

I look for greater simplicity and streamlining of the typical commercial hotel room of the future. The furniture in this room will be reduced to multiple purpose pieces and few of them. Each piece eliminated means one less to clean, polish and ultimately to refinish or replace. Over the useful life of a hotel operation, proper thinking directed into these channels can result in saving of thousands of dollars. These savings can be achieved and still give the guest all of the facilities he requires.

Time and motion study has a great potential field in our future. It can be applied to such functions as vacuuming, window washing, mopping, scrubbing and a countless variety of other everyday functions where productivity can be increased and the employe work load can be decreased. There is no question that a contented employe operating under a reasonable work load will yield a far greater proportion of production than will the employe who is harassed by sporadic work loads and laborious procedures.

In a great many aspects this represents a long-range program. As I stated earlier, one of the problems is the retraining of employes who are set in their habits. However, this is like many other problems of operation; there must be a beginning. Therefore, the housekeeping profession can perform no more useful task, in my opinion, than to investigate the full potentialities of the tool of time and motion study and to inaugurate comprehensive training programs which will benefit the whole field.

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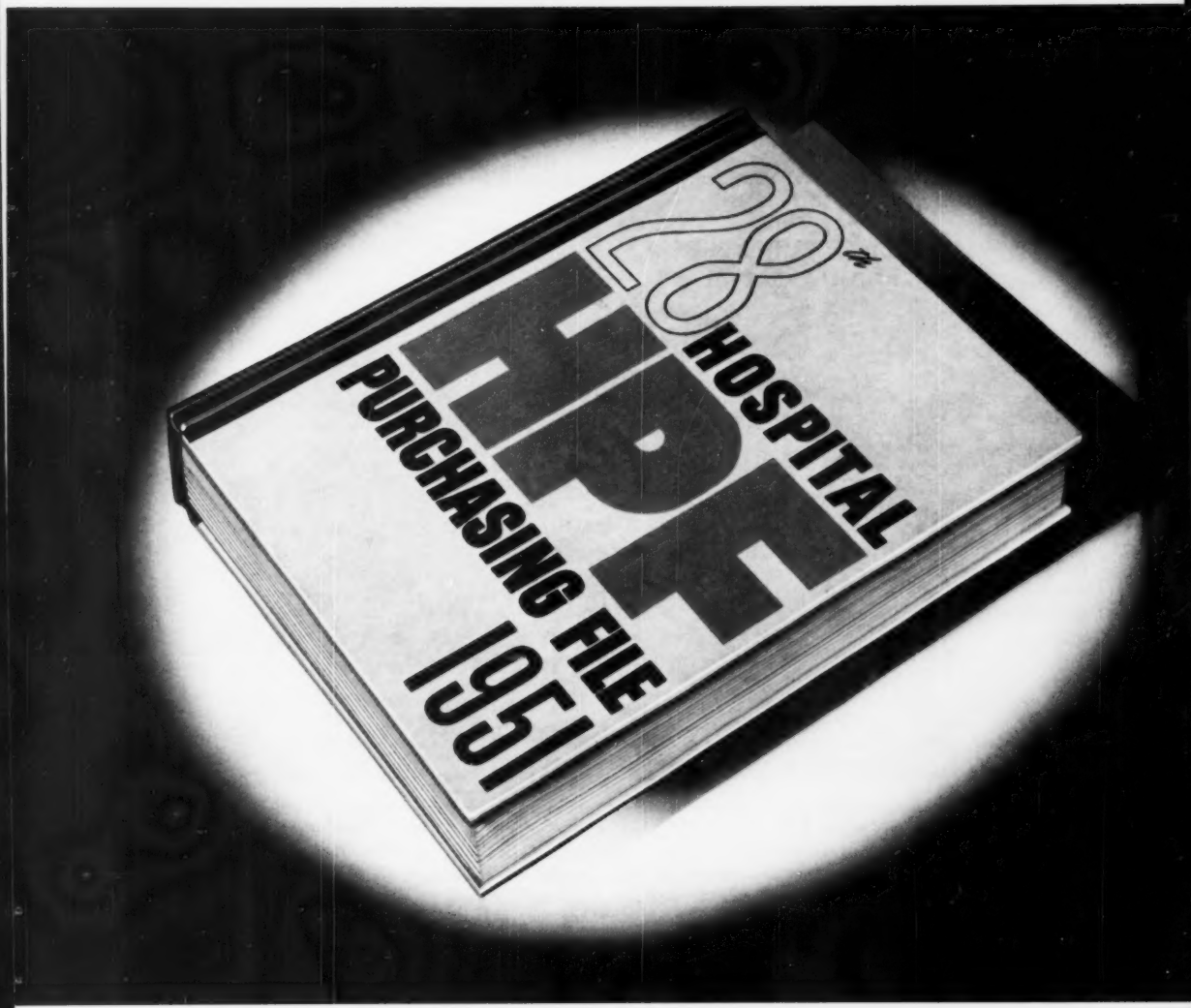

NEWS DIGEST

Blue Cross Commission Changes Approval Program . . . New York Court Holds Hospital Liable . . . Psychiatric Aide Competition Announced . . . Bugbee Explains A.H.A. Standardization Plan . . . Army Calls 650 Reserve Nurses

Blue Cross Commission Announces Changes in Approval Program

CHICAGO.—Changes in the Blue Cross approval program designed to facilitate the administration of the program were explained here last month by the Blue Cross commissioner. The changes were approved by the house of delegates of the American Hospital Association at Atlantic City September 17, the commission stated.

The new standards are more specific in terms of requirements for approval and more definitive on certain generally phrased points in the old standards, the commission explained. Of special interest to hospitals are the standards providing that "at least one-third of the members of a Blue Cross plan's governing board shall be representatives of the contracting hospitals" and that plan benefits shall cover "an average of not less than 75 per cent of the total amount billed for usual and customary hospital services."

The section on financial responsibility reiterates the former provision that Blue Cross plans shall produce satisfactory evidence when applying for approval to show that "reserves are adequate to protect hospital and subscribers' interests." Plans shall maintain written agreements with a majority of the hospitals in their area so as to be able to furnish benefits to all subscribers enrolled at any given time, the standards stipulate.

Other provisions in the revised standards call for the maintenance by the plans of accounting and statistical records as required by the Blue Cross Commission and assert that plan employes shall not be paid principally by commission or on a production fee basis. The standards also specify that board members shall receive no pay for their services as such.

The new standards also provide that plans "shall participate in all national programs in which at least three-fourths of all plans representing also at least three-fourths of the weighted vote of all plans are participating." National programs referred to include: transfer of members, hospitalization of members in areas served by another plan, and uniform enrollment and billing procedures for employes of national firms.

On the whole, the revised approval standards are more specific statements of the responsibility of hospitals and plans to Blue Cross subscribers and more concise descriptions of the relationship between hospitals and plans, subject in all cases to local laws or governmental regulations, the commission explained.

A.N.A. Appoints Committee on Nursing Resources

NEW YORK.—Appointment of a committee on nursing resources was announced here last month by the American Nurses' Association. Ella Best, executive secretary of the association, said the committee would study nursing services looking toward the provision of adequate organization and personnel to meet civilian and military needs during the coming years. Miss Best said the association has asked state and territorial organizations to appoint similar groups to cooperate with civil and military authorities to provide for nursing service.

"The best assurance of adequate nursing service for civil and military needs, now or in the future, is to know the status and availability of professional nurses, and to cooperate with the proper authorities in providing or obtaining nurses to serve where the need is the greatest."

Singsen and Wells Named Assistant Directors of Blue Cross Commission

CHICAGO.—Appointment of Antone G. Singsen and Lawrence C. Wells as assistant directors of the Blue Cross Commission here was announced last month by Richard M. Jones, director.

Mr. Singsen will assume responsibility for internal operations of the commission, including personnel, office management, the Inter-Plan Service Benefit Bank, and the actuarial and statistical activities, Mr. Jones said.

L. C. Wells

A. G. Singsen

Mr. Wells, who has been serving as manager of the public relations division of the commission, will be responsible for external operations, including public relations, enrollment, government relations and hospital relations activities, it was explained.

Appointment of Mr. Singsen and Mr. Wells was made following approval by the Blue Cross Commission of a reorganization of staff functions into internal and external sections, Mr. Jones said.

Plan 75 Bed Hospital

LAGUNA BEACH, CALIF.—Directors of the Hoag Memorial Hospital here have announced plans for a new 75 bed hospital, it was reported last month. Funds are at hand to provide the needed facility which is to be constructed at an estimated cost of $1,100,000.

NEWS...

Safeguards on Windows of Labor Rooms May Result From N.Y. Decision

NEW YORK.—New York hospitals would be required to provide bars or detention screens on labor room windows or have a nurse in constant attendance on patients in labor, according to the doctrine of unqualified liability upheld in a recent trial held in the state court of appeals. The court denied a motion for reargument of its decision in the case of Santos, administratrix of Ethel V. Flanagan, deceased, against the Unity Hospital, affirming a judgment against the hospital in the amount of $40,000. The action followed death of a patient who jumped from a window in the labor room during an advanced stage of labor.

There had been no history of mental or emotional disturbance, it was revealed during the trial; the patient had been left alone in the labor room for a few minutes while a nurse was answering the telephone.

The plaintiff charged negligence on the ground that no guard rails or locks on the windows were provided to safeguard deranged patients from harm, and that uninterrupted attendance on the patient was not furnished.

The court permitted the jury to decide whether the hospital was negligent in failing to provide bars on the windows, a procedure that was upheld on appeal.

In a minority opinion, two judges dissented from the view that the hospital had any liability. The dissenting judges stated that there was nothing in the history or condition of the patient to suggest an attempted suicide and no proof of any custom or requirement that windows in hospital labor rooms be safeguarded. The nursing attendance was adequate, and it was proper for the nurse to answer the telephone, according to the dissent. "I am unable to see how, on this proof, a finding of a breach of duty by this hospital can be sustained," the dissenting judge declared.

The Hospital Association of New York State and the Greater New York Hospital Association filed a memorandum supporting the hospital's petition for reargument of the decision. Member hospitals of both associations were vitally interested in the litigation, the memorandum pointed out.

"If the standard of care and the rules of law laid down by the majority opinion of the court of appeals are to be observed by hospitals in the State of New York," the association statement said, "it would be necessary to install bars on the windows of all rooms to guard against the remotest possibility that a patient, obstetrical, surgical or medical, may become psychotic, irrespective of any prior indication of mental disturbance. Hospitals in this state would have to become insurers of the safety of all patients, an impossible and unreasonable burden. The installation of bars in the windows would be in violation of fire and safety regulations and a menace to the lives of helpless patients in the event of fire or other danger.

"The additional requirement for constant nursing attendance for each patient, without interruption for any reason whatever, is a physical impossibility: at the present time there are not enough professional nurses to take care of the ordinary needs of the sick, both in and out of hospitals. Were it possible to obtain this additional nursing assistance, the cost both to the hospital and to the individual patients would make hospitalization prohibitive. Unless hospitals could collect from their patients for the extra cost, such institutions would soon become bankrupt.

"The happening of an accident such as occurred in the present case is so unusual an experience as to approach the unique. Reasonably prudent hospital management could not have anticipated what happened and should not have been expected to have anticipated any and all occurrences.

"On numerous occasions this court has ruled that a charitable hospital is not liable for acts of negligence committed by a professional nurse in the course of her professional duties, although there would be liability for administrative acts. In the instant case, the nurse was acting pursuant to the instructions and under the supervision of the attending physician.

"The new doctrine of unqualified liability as an insurer, pronounced by this court in the majority opinion, will make it impossible for hospitals to secure liability insurance. No insurance carrier will undertake so hazardous a risk as a hospital. The inability to obtain insurance coverage will imperil the very

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NEWS...

existence of all voluntary and private hospitals in this state.

"The interests of the voluntary and public hospitals in this state are closely identified with the public welfare. Any rule of law which is oppressive to these institutions and endangers their ability to function is contrary to the public interest."

Commenting on the case, Emanuel Hayt, counsel for the state hospital association, stated, "From a study of the majority opinion, which is now the law in this state, it would appear that hospitals are required to provide either (1) safeguards on the windows of labor rooms, such as detention screens, bars or other devices, or (2) have a nurse in constant attendance upon the patient while in the labor room."

Announces Competition for "Psychiatric Aide of Year"

NEW YORK.—A competition to select the "Psychiatric Aide of the Year" for 1950 was announced here last month by the National Association for Mental Health, Inc. The association is the successor organization to the National Committee for Mental Hygiene, the National Mental Health Foundation and the Psychiatric Foundation.

The competition will be the fourth annual program of this kind designed to select and recognize outstanding performance in the nonprofessional care of mental patients, it was explained. Previously the competition has been conducted by the National Mental Health Foundation.

"There has been a remarkable increase in the number of hospitals entering candidates each successive year," Paul Harris III of the association staff stated in announcing the 1950 competition. "This is evidenced by the fact that there were 65 per cent more hospitals participating in the 1949 event than was the case a year earlier. More and more hospitals are finding that this project not only is helping to gain long overdue recognition for the splendid services of their ward personnel, but also is helping the hospitals tremendously as a stimulant to community interest in their patients and program." Hospitals interested in details of the competition were invited to address inquiries to the National Association for Mental Health at 1790 Broadway, New York 19, N.Y., Mr. Harris said.

NEWS...

A.H.A. Standardization Plan Not Intended to Set Medical Standards, Bugbee States

CHICAGO.—The American Hospital Association has no desire to set medical standards, George Bugbee, association director, assured physicians in a statement released here last month in explanation of the association's recent action on hospital standardization program. Remarking that the association's house of delegates showed "remarkable firmness of intention that the A.H.A. should carry on a standardization, inspection and approval program," Mr. Bugbee added that this did not include the intention to set medical standards. Instead, "the board of trustees wants this done by physicians who have the backing of their profession, so that the standards will represent the best medical thinking and will receive general support," he declared.

"Many aspects of hospital standards relate to business procedures and to the various departments of hospital organization, such as medical records, dietetics and nursing. Here, the physician should share with the administrator and governing board the decision as to standards. Organizations representing related professional groups should be consulted in much the same manner as discussion goes on in the individual hospital.

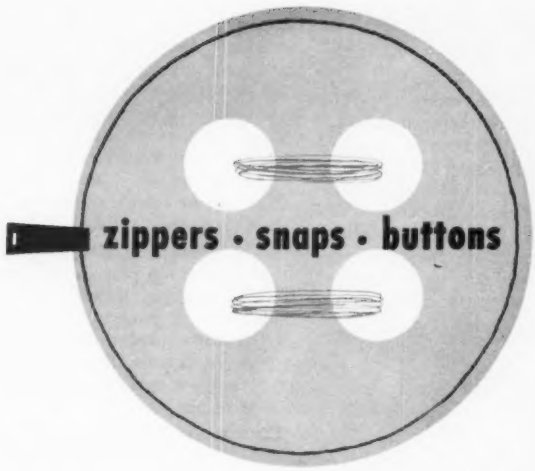
"The proposed hospital standardization commission, with representatives from hospital governing boards, medical staffs and administration, is no more than a national pattern for a national job of organizing within each hospital. There is certainly no desire on the part of hospitals to 'take over' the medical profession. This is a problem needing cooperation and a sharing of responsibility in the interest of continually improving the quality of hospital service. This is the whole aim of the American Hospital Association and the attitude of the board of trustees of A.H.A. as they are entering into discussions with the American Medical Association and the American College of Surgeons."

Transcribed Radio Programs Dramatizing Hospitals Offered by A.H.A.

CHICAGO.—Availability of a series of transcribed radio programs dramatizing hospital service was announced here last month by the American Hospital Association. The series consists of 13 transcribed programs running approximately 14 minutes each, to leave time for a local hospital message or a tie-in with a local fund-raising campaign.

The programs are released under the title, "At Your Service," and were prepared by Susan S. Jenkins, public relations director of Kansas City Blue Cross, and executive secretary of the Kansas City Area Hospital Council. Miss Jenkins is the author of a successful series of radio programs which has been presented by the Jackson County Medical Society.

"The transcriptions will be available to radio stations that have made arrangements with member hospitals in their community," the association announcement said. "Groups of hospitals are urged to approach station managers and sponsor the programs jointly. It is planned that the disks may be rented for a small charge or purchased. Detained information on how hospitals may obtain the transcriptions will be sent to members, hospital councils and associations and radio stations."



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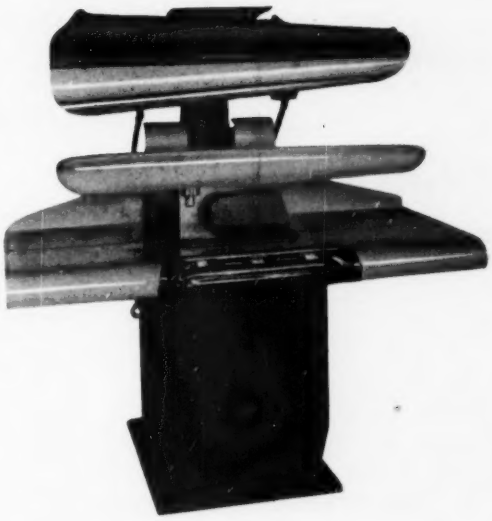

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NEWS...

Kellogg Foundation Awards $32,000 to Teachers College for Nurse Education Projects

NEW YORK.—A grant of $32,000 has been awarded to the division of nursing education of Teachers College, Columbia University, by the Kellogg Foundation to set up two projects to improve the training of students studying to be nursing administrators, it was announced by the university here last month. The first project is a teaching demonstration center in one or more hospitals in New York City, the announcement said. The centers will give on-the-job experience to future nursing administrators, it was explained.

The demonstration centers are part of a cooperative project between the division of nursing education of Teachers College and the hospital administration program in the School of Public Health of the university, Dr. R. Louise McManus, director of Teachers College nursing division, said. The demonstration centers would offer students several types of experience based on the team approach.

Students preparing to be directors of nursing and assistant nursing administrators would learn by observing and by actually engaging in nursing administration in the centers. The Delafield Hospital of the New York City department of hospitals and the Woman's Hospital will be used for student experience.

Students will get practice as staff nurses on a team basis. The centers will offer an internship program in nursing administration for nurses who have completed their program of organized study and who need closer experience to qualify as directors of nursing service and as assistant nursing administrators, Miss McManus stated.

Participation in on-the-job research related to the direct improvement of bedside nursing care of patients in the demonstration hospital will also be offered for students in this project, it was reported.

The second project under the grant will expand the educational offerings in the regular nursing program of the Teachers College nursing division, the announcement said. This project will also offer special educational services, including new courses leading to the position of assistant administrator of nursing service. It will develop field resources of the internship programs in nursing administration under the guidance of key nursing administrators, and obtain jobs for, and follow up, the students' progress during their internships.

Coroner's Jury Investigates Death of Four Infants

CHICAGO.—Continued study, including chemical analysis of infant formulas, water and cleaning fluids, was ordered by a coroner's jury investigating the death of four infants in the nursery of Grant Hospital here last month. Witnesses appearing at a preliminary inquest suggested that some toxic element in the dextrose product or evaporated milk used in the infants' formula was "probably responsible" for the illness afflicting 14 of the 24 infants in the hospital nursery.

Hospital officials testified that only infants which took the formula on one particular day became ill, while all infants in the nursery had taken water from bottles and nipples cleaned and sterilized by the same method.

NEWS...

Maine Hospital Administrators Attend Colby Institute

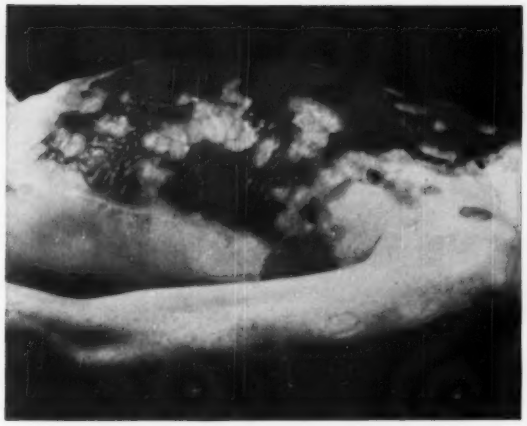
WATERVILLE, ME.—Attending the sixth annual Institute for Hospital Administrators, sponsored by the Maine Hospital Association at Colby College, Waterville, were some 24 hospital people from various parts of that state. Comprising the faculty for this institute's extension course, which was held in September, were Ellen G. Creamer, R.N., Columbia University, New York; Mrs. Amos F. Dixon, president, New Jersey Association of Hospital Auxiliaries, Newton, N.J.; Dr. T. Stewart Hamilton, director, Newton-Wellesley Hospital, Newton, Mass.; Dr. Frederick T. Hill, medical director, Thayer Hospital, past president, Maine Hospital Association, Waterville, Me.; Irving L. Hyland, A.I.A., A.H.A., engineer, James H. Ritchie & Associates, Boston; Mrs. Alta M. LaBelle, consultant, interior design, Dan Tames Company, Chicago; James H. Ritchie, A.I.A., A.H.A., architect, James H. Ritchie & Associates, Boston; Raymond P. Sloan, editor, The MODERN HOSPITAL, New York City, and Edward K. Warren, chairman, board of directors, the Greenwich Hospital Association, Greenwich, Conn.

Dr. Charles F. Wilinsky, president, American Hospital Association, director, Beth Israel Hospital, Boston, in his welcoming address stressed the keynote of the program which was that of sound administrative practice in the human and public relations phase of the hospital administrator's duties, particularly as applied to problems of the average New England hospital. Raymond P. Sloan, editor, The MODERN HOSPITAL, served as director, with Pearl R. Fisher, R.N., administrator, Thayer Hospital, Waterville, as assistant director.

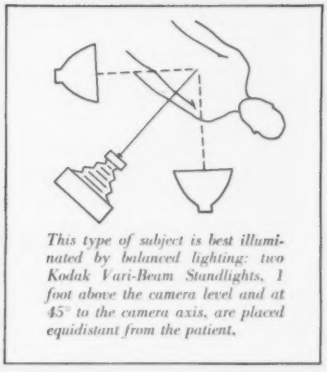
Registered in this year's course were Donald M. Rosenberger, Maine General Hospital, Portland; John C. Barker, Maine General Hospital, Portland; Frank L. Bosquet, Augusta General Hospital, Augusta; Mrs. Evelyn Barron, Portland City Hospital, Portland; Josephine Mizula, Portland City Hospital, Portland; Sister Hortense, Sister Bernadette, Sister Blanche, Sister Frances, Sisters' Hospital, Waterville; Edith Waddell, Presque Isle General Hospital, Presque Isle; Hope M. Hawkes, Milliken Memorial Hospital, Island Falls; Mabel Brackett, St. Andrews Hospital, Boothbay Harbor; Frances L. Crimmin, Augusta General Hospital, Augusta; Edward N. Powers, U.S. Marine Hospital, Portland; Sister Mary Mercy, Sister M. Annunciata, Mercy Hospital, Portland; Mrs. Dorothy Folta, Knox County General Hospital, Rockland; Etta M. Dodge, Miles Memorial Hospital, Damariscotta; Florence Sharpe, Agnes Flaherty, Carolyn Perkins, Maine Eye and Ear Infirmary, Portland; Merrill Tolman, Waldo County General Hospital, Belfast; Frank C. Curran, Eastern Maine General Hospital, Bangor, and Louise Laney, Thayer Hospital, Waterville.

MacEachern Receives LL.D.

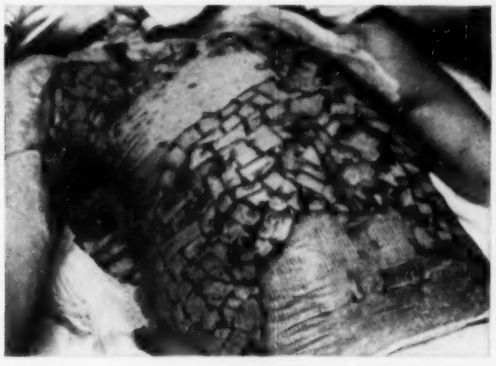
CHICAGO.—Dr. Malcolm T. MacEachern received an honorary doctor of laws degree from McGill University, Montreal, at the university's convocation last month. Dr. MacEachern is director emeritus of the American College of Surgeons here, and director of the program in hospital administration at Northwestern University. He received the M.D. degree at McGill University Medical School in 1910.



THIRD-DEGREE BURNS OF CHEST: LEFT—*Color visualizes effectively preoperative condition, showing granulations and surviving islands of skin.* BELOW—*Color depicts condition at first dressing, following split-thickness skin "stamp" grafting. (From Kodachrome transparencies.)*



This type of subject is best illuminated by balanced lighting: two Kodak Vari-Beam Standlights, 1 foot above the camera level and at 45° to the camera axis, are placed equidistant from the patient.



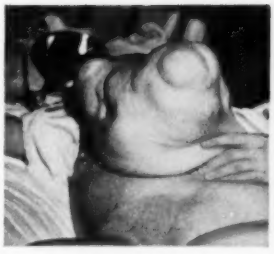
Picture the patient

in color . . . for greater realism

TO BE ABLE to show a clinical or surgical situation as the eye actually saw it . . . to be able to present the whole visual story again and again, more and more physicians are turning to color photography.

While notes, sketches, black-and-white photographs can preserve essential data, it takes the medium of color to complete many case histories . . . to provide the desired realism of all observable aspects. For the surgeon, the color is frequently the only feature that defines an area of infection . . . that distinguishes an anatomic lesion. For the pathologist, color is a criterion in establishing the identity of differentially stained tissues. These are some of the reasons why color photography is becoming routine in an increasing number of private offices, clinics, and hospitals . . . particularly in those institutions concerned with teaching.

Requirements in equipment and materials for photography in full color are easily met—camera with color-corrected lens . . . reliable light source . . . Kodak color film (Kodachrome or Kodak Ektachrome).



UMBILICAL HERNIA: *Color here presents dramatically the preoperative condition of this case. (From Kodachrome transparency.)*

One synchronized photoflash lamp at the camera lens provided sufficient illumination.

Serving medical progress through Photography and Radiography

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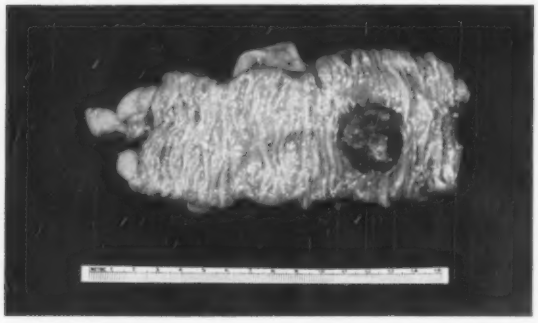
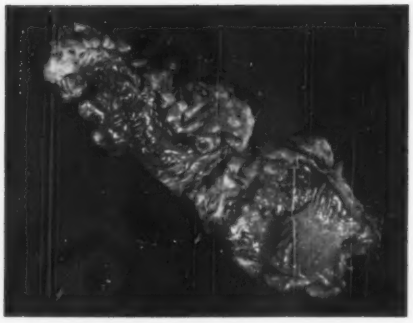
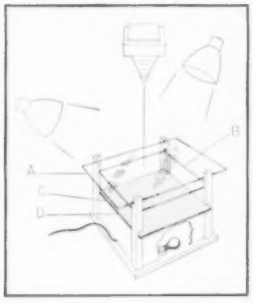
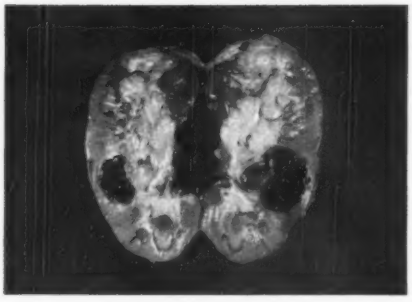






CARCINOMA OF SIGMOID (ABOVE); CARCINOMA OF RECTUM (UPPER RIGHT); CARCINOMA OF KIDNEY (RIGHT): *The use of color film and suitable contrasting transilluminated background vividly depicted these gross pathologic specimens. (From Kodachrome transparencies.)*

Specially constructed illuminator for photography of gross specimens with transilluminated color backgrounds. A—Clear plate glass (18x24 inches) for holding large specimen. B—Clear plate glass (10x18 inches) for smaller specimens. C—Transparent glass of desired color. D—Double-flashed opal glass to diffuse illumination from below.



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KODACHROME FILM *for miniature cameras . . . provides mounted transparencies for projection or prints.*

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NEWS...

Dr. Henderson Installed as President at Assembly of World Medical Association

NEW YORK.—Medical leaders of the world met here last month in the fourth general assembly of the World Medical Association, which is composed of national associations in 39 countries with a combined membership of nearly 500,000 physicians. Delegates from nearly all the organizations represented in the membership attended the meeting, it was reported, although war prevented the attendance of some delegates from the Far East.

Besides reporting on medical progress, delegates considered problems of the medical profession the world over as a result of war. Standards of medical care and allied subjects, medical education, standard nomenclature, international pharmacopeia and other subjects were discussed.

Shortly after the opening of the assembly, Dr. Elmer L. Henderson of Louisville, Ky., was installed as president. Dr. Henderson is also president of the American Medical Association.

The National Health Service continues to dominate the medical scene in Great Britain, the meeting was told in a report by Dr. Charles Hill of London, who preceded Dr. Henderson as president of the association. Dr. Hill is a member of Parliament and could not attend the meeting because Parliament is in session. He also is secretary of the British Medical Association.

He informed the world association that the British medical profession is continuing its negotiations with the government on matters arising from the operation of the service.

"Among the more important of these are the remuneration of practitioners, the grading and the terms and conditions of service of consultants and specialists in the hospital service, and the status of public health medical officers," he said.

"The branch of practice which is perhaps causing most concern is general practice. Part of the anxiety of general practitioners in the National Health Service is caused by the delay in settling the profession's claim for higher remuneration and failure to give an assurance that negotiations on general practitioners will always be conducted through conferences of representatives of the 'management' and 'staff' sides.

"So serious is the dissatisfaction of the profession with this uncertainty that

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a conference of representatives of local medical committees in June passed a resolution, which has been endorsed by the annual representative meeting of the British Medical Association, to the effect that if and when it becomes clear that there is no prospect of a satisfactory settlement, preparations should be made for a withdrawal of general practitioners from the National Health Service.

"Remuneration, however, is not the only factor which is worrying general practitioners. There is a feeling that general practice is losing its former prestige and status in the eyes of the profession as a whole and of the public.

"This loss, if it in fact exists, has no doubt been accelerated by the operation of the National Health Service, but there are certainly other causes at work, such as the increase of specialization and the social trends of recent years.

"The British Medical Association has decided to make a full investigation of the subject and has appointed a special committee to undertake the task."

650 Reserve Corps Nurses to Be Called by Army

WASHINGTON, D.C.—A total of 650 army nurse corps reserve officers in the grades of lieutenant and captain will be ordered to active duty before November 29, the Department of the Army announced here last month. Officers will be called "with or without their consent" up to the final date named, the Surgeon General stated. "The program of involuntary recall is being instituted to overcome the critical shortage of nurses now existing in military medical facilities," it was explained. Married nurses with dependents under 18 years of age are not eligible for call and are being separated from the Officers' Reserve Corps, it was stated. Nurse members of medical reserve units are subject to recall as individuals if their respective units have not yet been alerted for active duty, the announcement said. Deferment will be given to nurses "pursuing a full-time course of instruction on a university level," those who hold "key administrative or teaching positions in hospitals conducting training courses, and reservists whose entry on active duty might jeopardize the health of the community in which they are employed," the announcement said.

Also ordered to active duty are 145 officers in grades of lieutenant and captain in the Women's Medical Specialist Corps Reserve, it was announced. The total will include 70 dietitians, 40 physical therapists and 35 occupational therapists, it was explained. Those in full-time university courses will be deferred, as will women in key administrative or teaching positions and others whose entry on active duty might jeopardize the health of their communities.

Roosevelt Hospital Opens "Allergy Institute"

NEW YORK.—Establishment of an "allergy institute" was announced here last month by the Roosevelt Hospital. The institute is an outgrowth of an allergy clinic established at the hospital more than 30 years ago, Dr. Madison B. Brown, medical director, explained.

Purpose of the new institute will be to treat allergy sufferers, to teach diagnosis and treatment to medical students, and to conduct research in problems related to allergy.

A floor of one of the proposed new buildings to be erected at the hospital next year will be devoted to institute laboratories and clinics, it was explained.

NEWS...

Central New York Hospital Financial Officers Attend Workshop on Accounting

SYRACUSE, N.Y. — An accounting workshop for Central New York hospital financial officers was held here last month, sponsored by the Central New York Regional Hospital Council in cooperation with Syracuse University. Daniel S. Apgar, assistant superintendent of Crouse-Irving Hospital, Syracuse, said the purpose of the conference was to acquaint participants with current general accounting practice and procedures recommended by the American Hospital Association with a view to establishing comparable systems in hospitals in the Central New York area.

The small group conference technic was used to present the material most effectively, Dorothy Hehmann, executive secretary of the hospital council, reported. The participants were divided into two groups on the basis of whether their interest lay in hand or machine bookkeeping systems.

Left to right: Herman W. Fibiger, Ruth B. Welch, and Charles A. Lapham, of Syracuse, hear Arthur H. Hibson explain one of the financial problems studied at workshop.

The workshop was significant for excellent press relations, Miss Hehmann added. Frederick H. Sontag, public service director of Central New York Blue Cross, explained, "We are not just looking for material to fill space. We want the public to know that hospitals are concerned with the ever rising costs for anyone falling ill, and are trying to do something about it. By setting up common financial procedures, you will have an easier time to explain and prove to the public by your deeds that you are sincerely concerned about the public welfare, and not just hospital finance."

Six Weeks' Course in Laundry Management to Be Held at Iowa City

IOWA CITY, IOWA.—A six weeks' course in hospital laundry management will be offered here next winter by the State University of Iowa in cooperation with the American Hospital Association, the university's extension division announced last month. The program will be conducted during the period February 12 to March 30, 1951, the announcement said, using the facilities of the State University Hospital's laundry and laboratories. University staff members will instruct registrants, and classes have been planned to give practical instruction in hospital laundry management to those who participate. The course has been planned to give students a basic knowledge of laundry chemistry, textiles, personnel management, production management, record keeping, accounting, hospital organization, engineering and preparation of reports.

The enrollment fee for the course will be $95 plus living expenses. Ten scholarships of $275 each are available through the American Hospital Association and Pacific Mills, the university stated.

NEWS...

A.F.L. Union Employes Picket Portland Hospital to Enforce Wage Demand

PORTLAND, ORE.—Members of local 49 of the Service Employees Union, A.F.L., were picketing Emanuel Hospital here last month in an effort to enforce minimum wage demands characterized as excessive by Paul R. Hanson, hospital administrator.

Costs of hospitalization would advance to prohibitive levels, Mr. Hanson said, if the union's "capricious wage demands" were forced on Portland hospitals.

Minimum wages asked by the union ranged from $1.05 per hour for elevator operators to $1.80 an hour for wall washers, it was reported, with differentials for split shifts and night shifts. "The union's demands are out of line with prevailing wages paid in comparable private employment," Mr. Hanson said in a statement released to the public by the hospital. Thus "its action in attacking nonprofit community hospital service is particularly unwarranted.

"The hospital has followed the policy of conforming to wage scales in effect for unionized employes in Portland, such as laundry workers and dietary personnel. It has recognized its responsibility to be fair to its employes. It will continue to follow this policy."

The hospital statement indicated the hospital's average monthly pay roll for the first six months was $109,755. The monthly average pay roll would be increased by $67,154 under the wage scale demanded by the union, it was explained.

"Only two sources for the proposed increased wages are possible," Mr. Hanson declared. "Either the number of hospital employes might be drastically reduced, or hospital rates might be increased substantially. Either course is evidence of the unreasonable nature of this union's demands."

A statement made by several other hospitals in the Portland area expressed opposition to union contracts, apart from the specific wage demands, on the ground that the administration should not relinquish control of employe selection and duty assignment to "a third party who bears no responsibility for hospital operation."

Plan Episcopal Organization

OMAHA, NEB.—Arrangements have been made for an organizational meeting of Episcopal hospitals to be held in conjunction with the annual meeting of the American Protestant Hospital Association in Chicago next March, Hal G. Perrin, administrator of Bishop Clarkson Memorial Hospital and chairman of the Episcopal group's organization committee, announced last month. Mr. Perrin said that in addition to its organization functions the meeting would discuss the special problems of Episcopal institutions having to do with religious education, chaplain service, institutional chapels, and public relations opportunities.

Addition Nears Completion

HOLDREDGE, NEB.—An addition to the 60 bed Brewster Hospital and Clinic was nearing completion here last month, Harold Hamilton, administrator of the clinic, reported. The new building, latest of several additions to the original hospital structure, will add a number of beds and provide new lobby, reception room, diagnostic and service facilities.

NEWS...

Mrs. Roosevelt Receives Citation From Nurses

NEW YORK.—Eleanor Roosevelt was the featured speaker at a dinner here last month commemorating the 50th anniversary of the *American Journal of Nursing*. Mrs. Roosevelt addressed a group of nurse executives and guests on the subject, "The Nurses and the World of Tomorrow."

Mrs. Roosevelt was awarded a *Journal* citation for humanitarian service. The honor was conferred "for her warm response to people in need of help; for her achievements in assisting many peoples to improve their conditions of life; for her deep concern in the welfare of the young; for her spirited championship of democratic concepts and her unwavering attitude that fears and the sicknesses of society must be wiped away, allowing men and women everywhere to enjoy the fruits of freedom, health and individual labor," the citation said.

During its 50 years of operation, it was reported, the *Journal* has grown from a circulation of 550 for the first issue to 120,000 today. The magazine was launched "to present the news of the profession, the latest developments in care of the sick, and to campaign for better nurse training schools and for improvement in the status of the profession, better nursing service in hospitals and other health services," according to an association statement.

Among the important accomplishments of the *Journal* in its 50 years of publication was its support of state laws for registration of nurses, the association pointed out. The first of the state laws was passed by North Carolina in 1903, and the 48th state law was passed in Nevada 20 years later.

Thayer Cornerstone Is Laid

WATERVILLE, ME. — Ceremonies attendant upon the laying of the cornerstone of the new Thayer Hospital and Mansfield Memorial Clinic here took place in September. The new building, which is adjacent to the campus of Colby College, will provide 63 beds, with possible expansion to 85 beds or more, and represents an investment of $1,095,865. It is expected that the work will be completed early next summer. Architects are James H. Ritchie & Associates, Boston. Pearl R. Fisher is administrator, and Dr. Frederick T. Hill is medical director.

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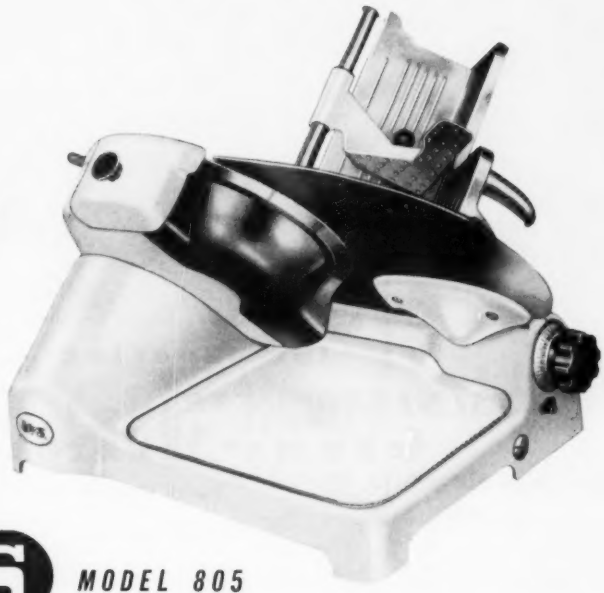

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NEWS...

Salt Water Is Effective Aid in Treatment of Shock and Burns—P.H.S.

WASHINGTON, D.C.—In a vast majority of cases, salt water taken by mouth is as effective as blood plasma in the emergency treatment of shock from serious burns and other injuries, the Public Health Service announced here last month following study of the problem by a group of leading American surgeons. The surgeons are members of the surgery study section, an advisory body to the National Institutes of Health and to the Surgeon General of the Public Health Service, it was explained.

In general terms, the treatment calls for approximately one level teaspoonful of table salt and one-half teaspoonful of baking soda for each quart of water, the surgeons found. A number of quarts are required each day. The only limitations on the amount consumed is the ability of the patient to consume the saline solution. Since great thirst accompanies serious burn injury, it has been found that patients will voluntarily consume a sufficient amount of the solution, which is quite palatable. No other drinking fluid is permitted in the first few days following injury, it was explained.

"The findings are of particular importance in a period of war emergency, since it is estimated that in the event of atomic bombing about 60 per cent of the surviving bombed population might suffer from burns," Surgeon General Leonard A. Scheele said. "This figure, moreover, does not account for injuries other than burns in which shock also might be present.

"Salt water offers an easy, practical method for the treatment of shock which follows serious burns and other injuries. It is particularly important in any period of large-scale disaster. Unless the patient is disoriented, is in acute collapse, or is among the very small percentage who become nauseated by drinking large quantities of the salt solution, the sodium chloride formula will be effective when administered by mouth."

Dr. Scheele emphasized the fact that treatment by saline solution will in no sense decrease the need for whole blood. Rather, he pointed out, sodium chloride would provide an effective immediate form of treatment which could be administered by anyone.

"The recommendation of the surgery study section, while of enormous benefit in the event of large-scale disaster, must not be construed as lessening in any way the importance of blood bank programs," he said. "Whole blood and plasma are still essential. We believe that the salt water method of treatment should also be included, however, in Red Cross training programs so that the necessary information may be fully available to all first-aid personnel, including firemen, policemen, air raid wardens and housewives."

Dedicate V.A. Hospital

GRAND ISLAND, NEB.—Opening of a new Veterans Administration hospital here was announced last month by Carl Gray, Veterans Administrator, who was principal speaker at the dedication ceremonies last summer. Following dedication of the hospital several thousand visitors toured the new building, which was opened for patients last month.

LINENS ARE AUTOMATICALLY *washed sterile-clean in this American Cascade Automatic Unloading Washer with Companion Control, then unloaded automatically into Notrux extractor containers.*

EXTRACTOR CONTAINERS *with washed work are quickly conveyed by hoist and overhead rail then lowered into Notrux extractor. Photos courtesy of American Laundry Machinery Company and Queen of Angels Hospital.*

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Savings of 400 Labor Hours a Week

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NEWS...

Foundation Will Undertake Study of Health Insurance

NEW YORK.—A study of health insurance will be undertaken shortly by the Health Information Foundation, Adm. William H. P. Blandy, foundation president, announced here last month at a meeting of the board of directors. The study will be undertaken with the assistance of "outstanding men in the Blue Cross, Blue Shield and private insurance fields," Admiral Blandy said.

The foundation's study of a multiphasic clinic operated in Richmond, Va., is in its final stages, Admiral Blandy reported. "It is hoped that we may give guidance to communities and groups throughout the country which are planning multiphasic projects," he said. "A complete program for dissemination of this information is being drafted."

Speaking of the forthcoming health insurance study, Admiral Blandy said the foundation's function would be to determine the essential principles to be incorporated in all plans in order to meet public need. "The problem of this study will be to inform the public of the results, and to inform ourselves, possibly to make a contribution toward improving such shortcomings as may be found in existing plans."

John G. Searle, chairman of the board of directors, said it was the foundation's aim to "become the clearing house for all things pertaining to information on health matters."

Civil Defense Problems Outlined by General

ATLANTIC CITY, N.J.—Organzation problems facing hospital and medical groups concerned with civil defense were outlined by Brig. Gen. James P. Cooney, chief of the radiological branch of the Atomic Energy Commission, at the annual banquet of the American Surgical Trade Association here in September. General Cooney addressed an audience of more than 500 association members and hospital administrators who were guests at the banquet. Prompt scientific therapy for burn victims will present a major task in event of attack by atomic bomb, General Cooney stated. He warned that panic caused by fear of bomb effects could easily be worse than the actual bomb damage if hospital, medical and civil defense authorities are not thoroughly organized in advance.

A.H.A. Announces Dates of Housekeeping Institute

CHICAGO.—An institute on hospital housekeeping will be conducted by the American Hospital Association in Chicago, December 4 to 8, Leonard P. Goudy, secretary of the association's council on administrative practice, announced last month. The institute is open to housekeepers and administrators of member hospitals of the association, the announcement said. Courses of study include institutional and departmental organization, personnel management, equipment and supplies, fire safety, sanitation, and selection and care of linens and furnishings.

Hospital Lacks Funds—Closes

MILAN, ILL.—The $150,000 Milan Hospital was closed here last month after three years of operation, it has been reported. The 30 bed institution was supported by public donations and had been unable to meet operating expenses, it was explained.

NEWS...

United Hospital Fund Seeks $3,500,000

NEW YORK.—The 72d annual United Hospital Fund compaign was opened here last month with a meeting at which O. Parker McComas, general campaign chairman, declared that hospitals are more important today than ever before in the nation's history.

The compaign quota of $3,500,000 is the largest in the history of the fund, Mr. McComas said. It will be used to aid 80 hospitals in the metropolitan area.

Gen. Lucius D. Clay, chairman of the New York State Civil Defense Commission, gave the principal address at the opening campaign meeting. Problems of civil defense were dramatized in a feature describing the rôle the city's voluntary hospitals would play if New York City were attacked by atomic bomb. Ben Grauer, N.B.C. announcer, was the narrator. Problems of civil defense have increased the need for good hospital care, the general said. He estimated that 100,000 persons might be injured in event of atomic attack on New York.

COMING MEETINGS

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, FELLOWS' SEMINAR, University of Chicago, Dec. 13-16.

ASSOCIATION OF CALIFORNIA HOSPITALS, Mar Monte Hotel, Santa Barbara, Nov. 14-16.

MICHIGAN HOSPITAL ASSOCIATION, Statler Hotel, Detroit, Nov. 12-14.

NEBRASKA HOSPITAL ASSEMBLY, Cornhusker Hotel, Nov. 16, 17.

ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 30-Nov. 1.

1951

ALABAMA HOSPITAL ASSOCIATION, Hotel Thomas Jefferson, Birmingham, March 9, 10.

AMERICAN HOSPITAL ASSOCIATION MIDYEAR CONFERENCE, Drake Hotel, Chicago, Feb. 9, 10.

AMERICAN HOSPITAL ASSOCIATION, St. Louis, Sept. 17-20.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Congress Hotel, Chicago, March 1, 2.

ARIZONA HOSPITAL ASSOCIATION, Adams Hotel, Phoenix, Feb. 16-17.

ARKANSAS HOSPITAL ASSOCIATION, Arlington Hotel, Hot Springs National Park, May 15, 16.

ASSOCIATION OF METHODIST HOSPITALS, Congress Hotel, Chicago, Feb. 28.-March 1.

ASSOCIATION OF WESTERN HOSPITALS, Biltmore Hotel, Los Angeles, April 30-May 3.

CAROLINAS-VIRGINIA HOSPITAL CONFERENCE, Roanoke Hotel, Roanoke, Va., April 26, 27.

CATHOLIC HOSPITAL ASSOCIATION, Philadelphia, June 2-5.

CONNECTICUT HOSPITAL ASSOCIATION, South New England Telephone Co., New Haven, Nov. 14.

FLORIDA HOSPITAL ASSOCIATION, Wyoming Hotel, Orlando, Dec. 4, 5.

GEORGIA HOSPITAL ASSOCIATION, Biltimore Hotel, Atlanta, Feb. 23, 24.

ILLINOIS HOSPITAL ASSOCIATION, Hotel Abraham Lincoln, Springfield, Nov. 29-Dec. 1.

KANSAS HOSPITAL ASSOCIATION, Allis Hotel, Wichita, Nov. 9, 10.

KENTUCKY HOSPITAL ASSOCIATION, Kentucky Hotel, Louisville, April 3-5.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 23-25.

MIDWEST HOSPITAL ASSOCIATION, President Hotel and Municipal Auditorium, Kansas City, Mo., April 11-13.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 26-28.

NEW JERSEY HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, May 24.

NEW MEXICO HOSPITAL ASSOCIATION, La Fonda Hotel, Santa Fe, May 18, 19.

OHIO HOSPITAL ASSOCIATION, Netherland Plaza Hotel, Cincinnati, April 2-5.

OKLAHOMA HOSPITAL ASSOCIATION, Skirvin Hotel, Oklahoma City, Nov. 16, 17.

SOUTHEASTERN HOSPITAL CONFERENCE, Vinoy Park Hotel, St. Petersburg, Fla., April 4-6.

SOUTHWIDE BAPTIST HOSPITAL ASSOCIATION, COMMISSION OF BENEVOLENT INSTITUTIONS OF THE EVANGELICAL AND REFORMED CHURCH, ASSOCIATION OF EPISCOPAL HOSPITALS, Congress Hotel, Chicago, Feb. 28, March 1.

TENNESSEE HOSPITAL ASSOCIATION, Read House, Chattanooga, May 3-5.

TEXAS HOSPITAL ASSOCIATION, Municipal Auditorium, San Antonio, April 24-26.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 30-May 2.

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COURTESY, KENTUCKY STATE MEDICAL ASSOCIATION

Ephraim McDowell

1771-1830

On December 13, 1809, Dr. Ephraim McDowell performed the operation in Danville, Ky., which earned him the title "The Father of Ovariotomy," when he removed fifteen pounds of ovarian tumor from a woman patient. The first operation of its kind was performed at his home while horrified, enraged citizens surrounded the house, prepared to hang the doctor. However, the townspeople who came to kill remained to cheer; his patient lived to be 80, and Dr. McDowell became world-famous for his surgical skill and pioneer courage.

Ephraim McDowell was born in Rockbridge County, Va., November 11, 1771. He attended a classical school at Georgetown, Va.; studied medicine under Dr. Humphreys, of Staunton, Va., and at the University of Edinburgh, Scotland, in 1793 and 1794. In 1795 he started to practice medicine and surgery in Danville.

Dr. McDowell was elected a member of the Medical Society of Philadelphia in 1817; was one of the founders and an original trustee of Center College, Danville, Ky., 1819-1823. He died in Danville on June 20, 1830. A marble monument was erected to his memory in McDowell Park, Danville, by the State medical society, in 1879, and in 1929 he was further honored by his native state when his statue was unveiled in Statuary Hall, United States Capitol, Washington, D. C., presented by the State of Kentucky.

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NEWS...

Beds in Military Hospitals Increased From 37,300 to 49,408, Meiling Reports

WASHINGTON, D.C.—Following charges by critics of former Defense Secretary Louis Johnson that an economy program in which several army hospitals were closed had interfered with proper care of army war casualties, Dr. Richard L. Meiling, director of medical services for the department, said here last month that the number of beds in military hospitals increased from 37,300 to 49,408 during the period July 1 to October 1.

Representative Shafer of Michigan had charged that military hospitals were 11,000 beds short of the number estimated to be needed by December 1.

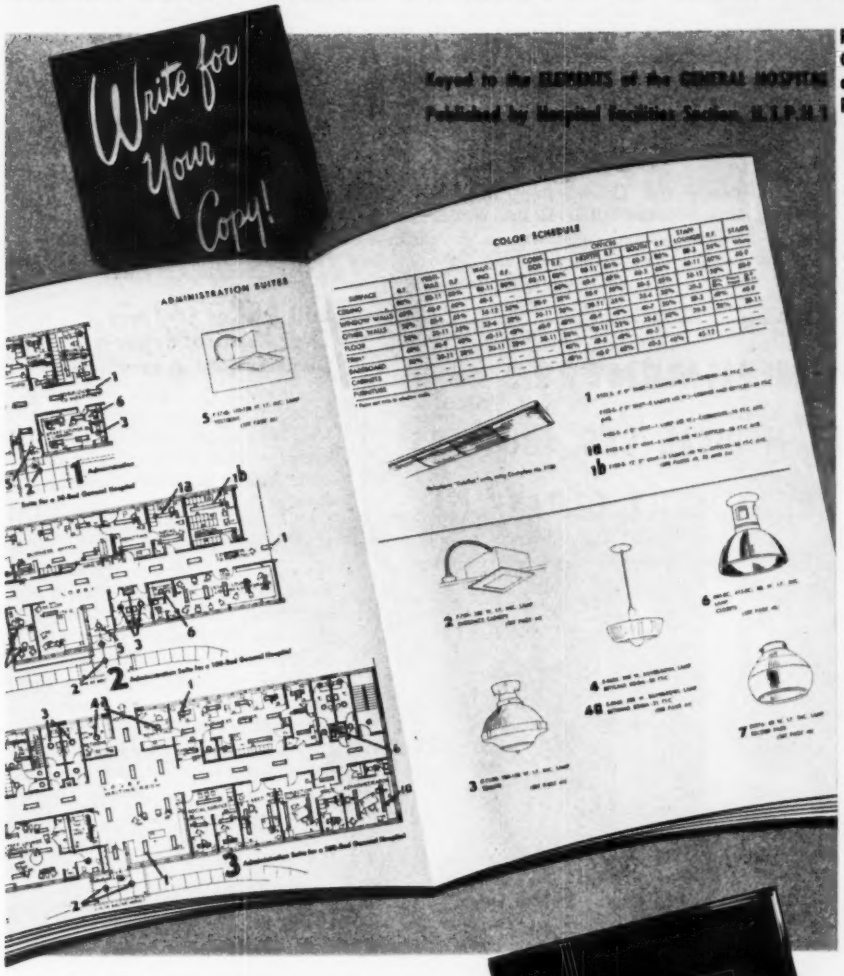
Dr. Meiling said the army had reopened closed hospitals at Valley Forge, Pa.; Waltham, Mass., and Battle Creek, Mich., "as a reserve against future emergencies," and the navy had "retained control over the closed hospital at San Leandro, Calif. With the increased flow of patients being returned from Japan and the concurrent expansion of the armed forces, need for additional medical care facilities has developed," Dr. Meiling stated. "The basic policy in the military hospital program is the joint use of military hospitals, by which members of the three military services may be cared for in the nearest hospital, regardless of the service which operates it."

College of Pathologists Holds Annual Meeting

CHICAGO.—Clinical discussions and study of the pathologist's rôle in civilian defense opened the program of the fourth annual meeting of the College of American Pathologists here last month. Administrative aspects of the pathologist's practice were presented in discussions at one session of the college by Dr. Harry P. Smith of Columbia University, Dr. John R. Schenken of the University of Nebraska and Dr. Donald A. Nickerson of Boston University.

George Hall of the Bureau of Legal Medicine and Legislation of the American Medical Association and Dr. Milton Helpern, medical examiner of New York City, discussed legal requirements in the practice of pathology. Dr. Harold S. Diehl addressed the annual banquet of the college on medical education under the British National Health Service.

HOLOPHANE GUIDE to HOSPITAL LIGHTING...



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Laundry
Local Corridors
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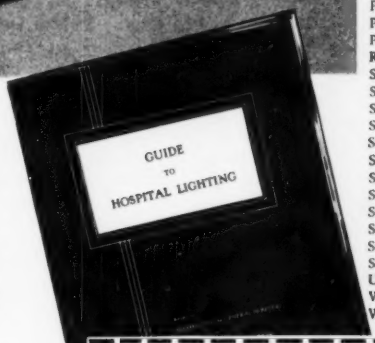
Morgue
Museum
Nurseries
Nurses' Locker Room
Nurses' Station
Nurses' Work Room
Occupational Therapy
Office for Exercise Areas
Operating Rooms
Pantries
Pharmacies
Physical Therapy
Playroom
Public Corridors
Public Lobby
Public Vestibule
Radiography
Sick Room 1 Bed
Sick Room 2 Bed
Sick Room 4 Bed
Soiled Linen
Solariums
Solution Rooms
Special Diets
Staff Lounge
Stairs
Sterilizing Areas
Storage
Surgical Corridors
Utility Rooms
Waiting Rooms
Wards



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NEWS...

Dr. Bachmeyer on Medical Emergency Committee

CHICAGO.—Dr. Arthur C. Bachmeyer, director of the University of Chicago Clinics, was named to membership on a Joint Committee of Medical Education in Time of National Emergency, it was announced here last month.

The committee was organized jointly by the Association of American Medical Colleges and the Council on Medical Education and Hospitals of the American Medical Association, it was explained, to "work out all problems relating to medical education during the current crisis and in event of another war."

Recommendations of the committee will be submitted to appropriate governmental agencies. The National Security Resources Board, Veterans Administration, Defense Department, and United States Public Health Service have appointed consultants to the committee.

Also named on the joint committee were Dr. Stockton Kimball, dean of the University of Buffalo Medical School, chairman; Dr. Joseph C. Hinsey, Cornell University Medical College; Dr. George Berry, Harvard Medical School; Dr. Herman G. Weiskotten, Syracuse University Medical School; Dr. Harvey B. Stone, Johns Hopkins University; Dr. Victor Johnson, Mayo Foundation; Dr. Donald G. Anderson, American Medical Association, and Dr. Harold S. Diehl, University of Minnesota Medical School.

Lull Denies Charges That Medical Schools Discriminate Against Jews

CHICAGO.—Charges that medical schools practice discrimination against Jews were characterized as false and labeled political demagoguery in a statement released here last month by Dr. George F. Lull, secretary and general manager of the American Medical Association. Dr. Lull's statement was made in a reply to an address to the American Jewish Congress by Federal Security Administrator Oscar Ewing, who cited a report by the President's Commission on Higher Education indicating that the percentage of Jewish students in medical schools had dropped during the period 1935 to 1946 while the total number of students was increasing. Mr. Ewing also charged the American Medical Association had "blocked" federal aid to medical education.

Replying to the Ewing charges, Dr. Lull described the administrator as a "disappointed and embittered bureaucrat." Mr. Ewing "descended to the depths of political demagoguery" when he implied the medical schools were practicing discrimination against Jews, Dr. Lull stated.

N.Y. Buses Into Ambulances

NEW YORK. — Specially designed brackets that can be used to hold stretchers and thus convert city buses into ambulances have been ordered by New York City's board of transportation, Sidney H. Bingham, board chairman, announced here last month. Mr. Bingham said the city has 500 buses with doors wide enough to accommodate stretchers. Each bus can take 14 stretchers in addition to 25 seated passengers. Transportation facilities must be given a high priority in defense plans, Mr. Bingham said.

Dr. Mary Bryan Receives Marjorie Hulsinger Copher Award at A.D.A. Meeting

By MARY P. HUDDLESON

WASHINGTON, D.C.—Total registration at the 33d annual meeting of the American Dietetic Association here October 16 to 20 was estimated at well over 3500.

Officers named for 1950-51 are: president, Dr. Lillian Storm Coover, consultant, Gerber Products Company, Ames, Iowa; president-elect, Dr. Margaret Ohlson, head, department of foods and nutrition, Michigan State College, Lansing; speaker of the house of delegates, Dr. Helen S. Mitchell, dean, school of home economics, University of Massachusetts, Amherst; secretary, Marguerite L. Pettee, nutritionist, department of obstetrics and gynecology, Medical Center, University of Colorado, Denver, and, treasurer, Mrs. Winifred H. Erickson, head dietitian, Ancker Hospital, St. Paul.

At the annual banquet, at which Elizabeth Perry, retiring president, presided, the Marjorie Hulsinger Copher Memorial Award for 1950 was presented to Dr. Mary DeGarmo Bryan, president of the association in 1920-22, now professor and head of the department of institution management, Teachers College, Columbia University. The citation read, in part, "in recognition of her leadership, her integrity and devotion to her profession's advancement, her signal achievements as dietitian, teacher and authority in institution management . . . and resilience of spirit that has inspired her associates to new heights of attainment."

The Mary Swartz Rose Fellowship for 1950 was presented to Pearl Jackson by Dr. Grace MacLeod, a close associate of Mrs. Rose for many years.

Of special interest to members were the exhibits describing the activities of the Air Force Women's Medical Specialist Corps and that of the army. Visits were also arranged to Bolling Air Force Base and to the Army Medical Center. The tremendous scope of dietitians' activities and their operational functions in the 140 hospitals of the Veterans Administration were also highlighted in booths manned by smartly uniformed members of the headquarters staff.

The probable demands upon dietitians as a result of the international situation were stressed by several speakers. In addition, the members were also alerted to the problems of atomic warfare by Brig. Gen. James P. Cooney, chief, radiology branch, U.S. Atomic Energy Commission.

Perhaps the outstanding theme of the week's program concerned the needs of a population and a profession now in its 33d year of organized activity. Members' names and affiliations were displayed in type size that was easily readable without bifocals.

Ewan Clague, U.S. Commissioner of Labor Statistics, reviewed the employment problems of older workers. With the advancing life span, said Mr. Clague, "we need to know more about the types of jobs older people do or can do, their relative work performance, the special obstacles that may exist in their employment, and the programs which have been adopted by employers to increase their utilization."

Special procedures are also needed for training and counseling older people, the speaker asserted. He added, "we all know men and women who at 60 are more alert and in better physical condition than are people 10 or 20 years their junior."

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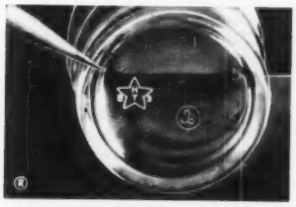

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cussed by Jerome Gottschalk, president of Counselors, Inc., Chicago. Immature leaders, he said, cannot inspire confidence in the peoples or organizations they direct. Maturity must be an integral part of the life of business, professional and political leaders. Immaturity means inefficiency and tension, not only for the immature but also for all who are a part of the "collapsing structure" they direct.

Other speakers, notably Vera W. Walker, consultant on standards of assistance, Florida State Welfare Board, discussed the growing problem of homes for the aged and the food service therein. In 21 states at least 75,000 residents and staff members are housed in such homes, but in only nine of the 21 are dietitians serving in these institutions. At present the population increase in persons over 65 is almost five times that of the whole population.

Dr. Wilma T. Donahue, psychologist, University of Michigan, viewed the problem from another angle. "Overeating," she said, "may reflect the emotional poverty of the lives of old people." Others, left alone, may like a child refuse to eat. The older patient should be allowed less time "for introspection and contemplation of the idiosyncrasies of the alimentary canal."

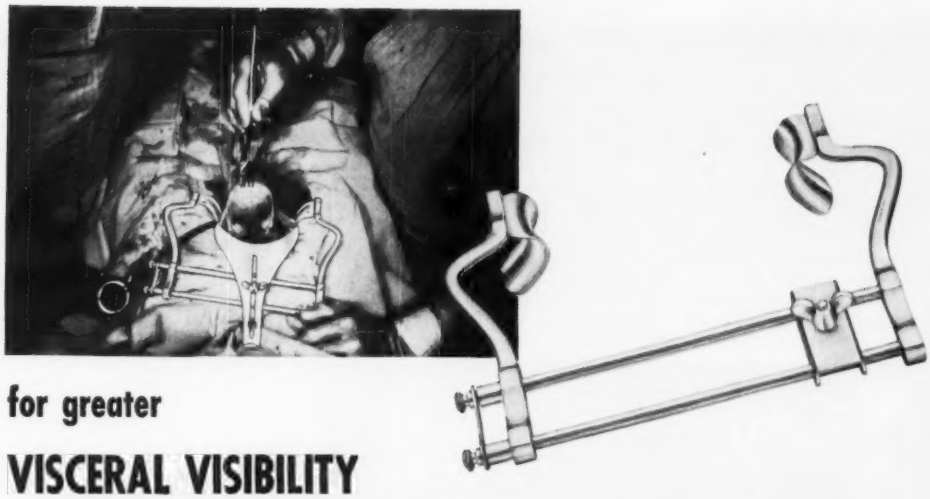
Apropos the demands made on today's dietitian, sympathy was expressed by Dr. J. R. McGibony, chief, Division of Medical and Hospital Resources, U. S. Public Health Service. Said Dr. McGibony, "We expect the modern dietitian to be everything from a financial wizard to a sanitation expert; a combination of artist, psychologist, diplomat, manager and teacher." Concerned over the shortage of dietitians and an accelerated demand for hospitals, Dr. McGibony emphasized the coordination of hospitals as one answer to the need for adequate food service in hospitals.

The most advanced plans for construction of the Clinical Center, National Institutes of Health, Bethesda, Md., were detailed by Dr. Jack Masur, director. Schematic drawings were shown of the main kitchen, metabolic kitchen, rapid service pantries, and radiation wing pantries in this proposed 14 story structure, with its 3000 employes. Equipment of the new center will include many "firsts" in hospital construction. Even a "banana room" will be provided with the temperature suited to storage of this fruit.

Naturally, the never completed answers to the problems of promoting employe cooperation, working relationships, work simplification, and so forth were discussed throughout the week, with many speakers contributing. Again, the employes' check list for the desirability of a job was stated as: (1) dignity on the job, (2) humane treatment, (3) fair pay and job security, (4) opportunity for growth and personal development.

Unit menus *versus* master menus, with strong approval of the former, were discussed by Martha McBride, administrative dietitian, Indiana University. Plastic tableware was discussed by a chemical engineer, Charles N. Gardner, of the Office of the Quartermaster-General. These and a generous number of other very practical discussions of administrative problems were presented daily to enthusiastic audiences often of "standee" proportions.

A vast commercial exhibit, with everything from a new and reportedly safe substitute for salt to almost every conceivable machine or device for work once performed by human hands, was displayed in spacious and pleasant surroundings.



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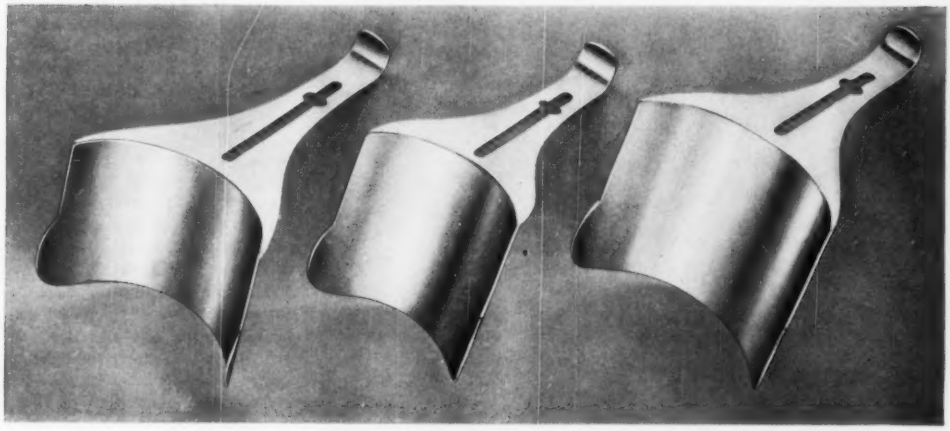

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Consider Consolidation of Two N.Y. Hospitals

TARRYTOWN, N.Y.—Consolidation of the Tarrytown and Ossining hospitals in the Hudson Valley area is under consideration, it has been reported here. The plan contemplates a merger and construction of a $3,500,000 building in Mt. Pleasant Township near here.

The merger plan follows recommendations made in a survey of the area hospital needs completed two years ago and is in accordance with petitions recently circulated by local residents.

ABOUT PEOPLE

(*Continued From Page* 88.)

L. W. Days

Leonard W. Days has been appointed superintendent of the Pasadena Dispensary, Pasadena, Calif., replacing **Verna E. Bowman, R.N.,** who retired after 29 years with the dispensary. Mr. Days, who until recently was assistant manager of the Veterans Administration Hospital at Bedford, Mass., was formerly chief, hospitalization section, Veterans Administration, central office, Washington, D.C. He was a major in the medical administrative corps in World War II, and is a nominee in the American College of Hospital Administrators.

Martin James Foerster has replaced **A. F. Wasson** as administrator of Memorial Hospital, Hugo, Okla. Mr. Foerster also will serve as laboratory x-ray technician at the hospital.

E. R. Andres, administrator of Midland Memorial Hospital, Midland, Tex., resigned last month. Mr. Andres had been associated with the new hospital, which was opened July 11, since 1948.

Mabel Davies, superintendent of Beekman-Downtown Hospital, New York City, was honored recently with a reception on the occasion of her 25th anniversary as superintendent of the hospital.

Rev. W. W. Ward has been named acting administrator of Harris Hospital, Fort Worth, Tex., to fill the vacancy caused by the resignation of the administrator, **Harold A. Sayles.**

Selma Kruse, superintendent of Mercedes General Hospital, Mercedes, Tex., since February 1949, was married late in August to George Erchinger of Mercedes. Mrs. Erchinger will retain her position at the hospital.

Walter J. Dawson Jr., assistant administrator of St. Luke's Hospital, Duluth, Minn., and **Ronald A. Jydstrup,** assistant administrator of Robert Packer Hospital, Sayre, Pa., won the 1950 Hamilton awards for scholastic prowess while students in the course in hospital administration at the University of Minnesota. Mr. Dawson earned the James A. Hamilton award given to the member of the class of 1950 whom the faculty considered most likely to succeed; Mr. Jydstrup received the Sabra M. Hamilton award for the best management research report by a member of the same class. The awards were presented during the Atlantic City convention of the American Hospital Association.

Paul E. Loubris has resigned as assistant director of the Lankenau Hospital, Philadelphia. He will assume his new position as administrator of Clearfield Hospital, Clearfield, Pa., in November. He has been assistant director of the Lankenau Hospital for the last two years, and prior to that was assistant director of the Germantown Hospital in Philadelphia under **Dr. Donald C.**

Smelzer. Mr. Loubris is a member of the American College of Hospital Administrators, American, Pennsylvania and Philadelphia hospital associations and is one of the founders of the Hospital Purchasing Service of Pennsylvania, having served as a director on the board from its inception.

Robert Guy, who was formerly associated with the Baptist Hospital in Atlanta, Ga., has been named administrator of Baton Rouge General Hospital, Louisiana. He assumed his new duties October 17.

Dr. Hiroshi Moriya, staff member of the First National Hospital, Tokyo, Japan, has arrived in the United States to study hospital administration under the sponsorship of the U.S. Public Health Service. He will study at Northwestern University.

William Nichols, a graduate of the course in hospital administration at Washington University, St. Louis, has been appointed assistant superintendent of St. Louis County Hospital. Mr. Nichols was elected a nominee of the American College of Hospital Administrators at the A.C.H.A. meeting held in Atlantic City in September.

Frank Harris has been named administrator of the new County Hospital at Kennett, Mo., which is now under construction. The hospital is scheduled to open in January 1951.

John Barry has assumed his duties as administrator of Torbett Clinic and Hospital, Marlin, Tex.

Dr. John A. Seaberg has been appointed manager of the Veterans Administration Hospital in Minneapolis. He replaced **Dr. Edwin J. Rose** who has been transferred to the V.A. central office in Washington, D.C., as assistant director of the hospital operations service of the Department of Medicine and Surgery. Dr. Seaberg has been associated with the Minneapolis hospital in various capacities since 1924.

W. P. Geigenmuller

Werner P. Geigenmuller has been appointed assistant superintendent of Stanford University Hospital. Mr. Geigenmuller has been assistant to the superintendent for the last four and a half years. Prior to that he served for three years in the army with the medical corps, and was released with the rank of captain. Mr. Geigenmuller has been connected with the hospital field for the last 15 years, having been connected with Franklin Hospital and Mt. Zion Hospital in San Francisco before coming to Stanford. At present Mr. Geigenmuller is the president of the Hospital Economic Section for Northern California, and has been a member of that organization for the last 10 years.

E. Reid Caddy, for the last seven years director, St. John's Episcopal Hospital, Brooklyn, N.Y., has resigned his position.

Department Heads

Lonnie Jane Rainey is now director of the undergraduate nursing program at the University of Houston School of Nursing. Her former nursing affiliations have been with Overlook Hospital, Summit, N.J., Jefferson Davis Hospital, Houston, Tex., and Jewish Hospital, Brooklyn, N.Y.

Steve Stefansky is the new chief engineer at Michael Reese Hospital, Chicago. A graduate of Armour Institute of Technology, Mr. Stefansky worked as general engineer of the Stevens Hotel in Chicago for six years.

Dr. Aims C. McGuinness, director of

Children's Hospital, Philadelphia, has been named dean of the University of Pennsylvania's Graduate School of Medicine to succeed **Dr. William S. Parker,** who resigned recently. Dr. McGuinness will assume his new duties January 1.

Jean A. Bergfalk, who holds the degree of registered record librarian from the College of St. Scholastica, Duluth, Minn., has been appointed to the staff of Walter Reed General Hospital, Washington, D.C. She comes to Walter Reed from the Portsmouth U.S. Naval Hospital, Portsmouth, Va.

Margaret Nelson, administrative supervisor of Baylor University's Florence Nightingale Hospital for five years, has joined the Methodist Hospital of Dallas, Tex., as director of nursing service.

Mrs. Frances Meservey has been appointed director of nurses at Huntington Hospital, Huntington, L.I. Mrs. Meservey had been assistant supervisor of the hospital on night duty.

Dr. Robert W. Berliner, assistant professor of medicine at Columbia University, has been appointed chief of the laboratory and clinical section on kidney and electrolyte metabolism of the National Heart Institute, Washington, D.C.

C. Bowman

Claire Bowman, R.N., has been named director of nursing service and education by the Wyoming County Community Hospital, Warsaw, N.Y. Miss Bowman was assistant director of nursing at Sibley Memorial Hospital, Washington, D.C., for three years until September 1949, when she entered a year's postgraduate study in the field of nursing education at Columbia University.

Mrs. Babette Jennings, director of the outpatient and social service departments at Children's Memorial Hospital, Chicago, since 1929, is retiring. **Mildred Louise Jennings,** assistant director of the outpatient department and case supervisor since 1941, has been appointed director of the outpatient department. **Marie Waite,** formerly of the University of Chicago Clinics, has been appointed director of the social service department. When Mrs. Jennings was appointed director of the two departments in 1929, she succeeded **Mabel W. Binner,** who then became administrator.

Agnes M. Dunn, former supervisor of obstetrics at Sloane Hospital for Women, a part of the Columbia-Presbyterian Medical Center, New York City, will direct a new obstetrical division at Stamford Hospital, Stamford, Conn.

Claire H. Fabreau has been appointed assistant professor and director of the nursing education division of the School of General Studies of Hunter College, New York City. She is replacing **Winifred Kaltenbach,** the acting director. At the same time it was announced that **Mrs. Kathleen Guinee** has been made full-time instructor in the college's division of nursing education.

Miscellaneous

Dr. Leona Baumgartner, on leave of absence from the New York City Health Department since June 1949, has returned to her post there as assistant commissioner of health. During her leave of absence Dr. Baumgartner served as associate chief of the children's bureau in the Federal Security Agency. She will remain with the federal agency as an unsalaried special consultant.

Dr. Henry A. Davidson has been appointed by the Veterans Administration as chief of psychiatry for the nine states in the Washington, D.C., area medical office. Dr. Davidson has been chief of psychiatry at the Newark, N.J., V.A. regional office since March 1947.

XAVIER HOSPITAL
DUBUQUE, IOWA

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Odorless Wall Paint Increases Occupancy!

BUILT on a hill high above the Mississippi River, Xavier Hospital, Dubuque, has been operated by the Sisters of St. Francis Xavier since its opening in March, 1949. About one-third of its activities are devoted to the care of infirm, aged sisters and the clergy, who occupy one wing of the building.

A connecting link — physically and spiritually — between the hospital and the clergy's wing is the Sisters' attractive chapel with its sapphire-stained windows and fiddle-back mahogany paneling.

The services of the building are centrally located around the core of elevators. Every effort has been made to simplify operational problems through logical planning and the use of improved technical equipment.

As in many other hospitals decorated with Pratt & Lambert Paint and Varnish, P&L **odorless** wall coatings have outstanding advantages: they are free of eye-smarting fumes; reduce vacancies; withstand repeated washing; assure economical maintenance.

Write for color suggestions and painting specifications. Pratt & Lambert-Inc., 126 Tonawanda St., Buffalo 7, N. Y. In Canada, 18 Courtwright St., Fort Erie, Ontario.

Save the surface
and you save all!

PRATT & LAMBERT PAINT AND VARNISH

Dr. George Rosen has resigned as director of the bureau of health education of the New York City Department of Health to become associate director of the Health Insurance Plan of Greater New York.

Dr. William H. Sebrell has succeeded **Dr. Rolla E. Dyer** as director of the National Institutes of Health, Public Health Service, Washington, D.C. Dr. Dyer retired from the federal service October 1.

Philip E. Nelbach recently joined the staff of the National Health Council, New York City, as associate director. Trained in business administration at Yale University, he also has a master's degree in public health from Yale, where he was assistant professor of public health.

Dr. Charles Buckman has been appointed assistant commissioner of the New York State Department of Mental Hygiene, according to an announcement by **Dr. Newton Bigelow,** commissioner. Dr. Buckman has been director of Gowanda State Hospital, Helmuth, N.Y., since May 1949.

Sallie Jeffries, chief consultant in nursing of the Bureau of Indian Affairs, Department of the Interior, retired October 10 after 21 years of service.

Deaths

Dr. James F. Norton, former vice president of the American Medical Association and former president of the Medical Society of New Jersey, died suddenly September 27 at his home in Jersey City, N.J. He was 57 years old.

Dr. James Sonnett Greene, 69, medical director of the National Hospital for Speech Disorders, New York City, died unexpectedly September 18 at his summer home in Neponsit, Queens, N.Y. Dr. Greene and his wife founded the National Hospital for Speech Disorders in 1916.

Ida D. Squarewood, R.N., former superintendent and superintendent of nurses at Bridgeton Hospital, Bridgeton, N.J., died there recently at the age of 68 years. Miss Squarewood joined the Bridgeton staff as a nurse in 1910.

Fail to Meet Standards

TRENTON, N.J.—Thirty per cent of general hospitals in New Jersey failed to meet minimum standards established for licensure, Commissioner Sanford Bates announced last month following completion of a statewide hospital survey. The report by the department's hospital inspection and licensing division said that 40 per cent of hospitals were substandard and 10 per cent received temporary licenses. In most cases substandard hospitals have cooperated in compliance with department recommendations, it was explained. Three hospitals which found it financially impossible to meet minimum requirements have been closed, the report said.

Names of the substandard hospitals were not released in the report which was made public.

Norwalk Campaigns for Wing

NORWALK, CONN.—A campaign for $780,000 to finance construction of a new wing for the Norwalk Hospital was opened here last month. Victor Knauth, executive chairman for the campaign, said the building was needed to relieve overcrowded conditions in patients' rooms, clinics and diagnostic facilities of the hospital. A building costing $1,460,000 is planned. A total of $380,000 is already available in previous contributions, Mr. Knauth said, and it was expected that the hospital would receive a grant of funds under the Hill-Burton Act.

NEWS...

Oregon Medical Society Held Not Guilty of Monopoly

PORTLAND, ORE.—The Oregon State Medical Society and its prepayment affiliate Oregon Physicians' Service are not guilty of a conspiracy to monopolize prepaid medical care, Federal Judge Claude McCulloch ruled here last month.

The state medical society, Oregon Physicians' Service, a number of county societies and several individual physicians here were charged with violation of the Sherman Anti-Trust Act in an action taken two years ago by the federal government.

"I hold that the Oregon Physicians' Service is not a conspiracy," Judge McCulloch stated, "but rather an entirely legal and legitimate effort by the profession to meet the demands of the times for broadened medical and hospital service, eliminating the evils of privately owned concerns as well as the element of private profit."

The federal government had charged the defendants with monopolizing the field of prepaid medical care by refusing to deal with private agencies and by "disciplining" physicians who did not participate in the defendants' plans.

Name Organization Committee for N.Y. Hospital Board

NEW YORK.—Appointment of a committee of organization of the newly created city board of hospitals was announced here last month by Dr. Marcus D. Kogel, city commissioner of hospitals, following the first meeting of the new board. Dr. Kogel characterized the board's meeting as "an historic occasion." He said the board should be a force for great good in the community, as hospitals were currently engaged in the greatest expansion program in the city's history. Dr. Willard C. Rappeleye, vice president in charge of medical affairs of Columbia University, was named as chairman of the organization group. Other members included Dr. Edward M. Bernecker, administrator of hospital services of New York University-Bellevue Medical Center, and Alfred P. Sloan Jr. of the Sloan-Kettering Institute for Cancer Research.

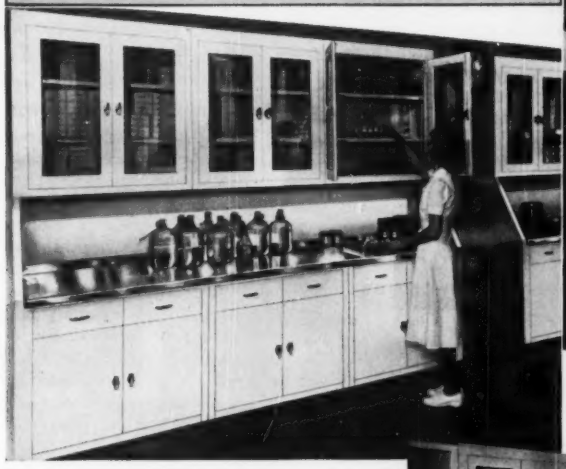
The organization committee will make recommendations for organization of special groups to be named on hospital construction and long-range planning, promulgation of a hospital code, budget problems, professional service and proprietary hospital licensure, Dr. Kogel said.

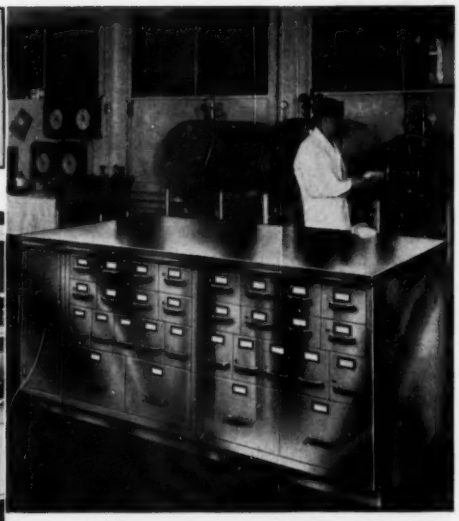
Clinic Administrators Meet

WHITE SULPHUR SPRINGS, W.VA.—The American College of Clinic Administrators held its first annual meeting here last month. R. J. Wilkinson Jr., Huntington, W.Va., was named president for the coming year. E. R. Denison, Philippi, W.Va., was elected vice president; and Carl R. Parrish, Richmond, Va., secretary-treasurer.

Honorary fellowships were bestowed on the following members: Dr. H. C. Myers, Philippi, W.Va.; Dr. Robert K. Buford, Charleston, W.Va.; Dr. R. J. Wilkinson, Huntington, W.Va.; Dr. Herbert Acuff, Knoxville, Tenn., and John R. Mannix, Cleveland. The college plans to devote its activities to the fields of scholarship in clinic administration and standardization of clinics, it was explained.

SHAMPAINE





Shampaine all stainless steel drawer cabinet in the central sterilizing room of a San Francisco hospital.

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Shampaine custom-built casework assures complete and lasting satisfaction because it is expressly designed for you — to meet your exacting plans and specifications.

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Shampaine custom-built casework brings you the perfect fit, smooth operation and gleaming, aseptic finish that have marked Shampaine quality products for over a quarter century.

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NEWS...

Nurse Anesthetists Plan School Accreditation Program

CHICAGO.—A plan for accreditation of schools of anesthesia for nurses was unanimously approved at the 17th annual meeting of the American Association of Nurse Anesthetists, it was announced at association headquarters here last month. The plan calls for workshops through which criteria for accreditation of nurse anesthetists' schools will be developed.

Members voted to increase active membership dues to $20 in order to support the accreditation program, the report said.

Verna E. Bean of Lexington, Ky., was named president of the association at the meeting, which was held at Atlantic City in conjunction with the American Hospital Association convention. Other officers named were: Josephine Bunch, Portland, Ore., 1st vice president; Minnie V. Haas, Fort Worth, Tex., 2d vice president; Agnes Lange, Chicago, treasurer; Harriet Aberg, Galesburg, Ill., Hazel Peterson, Minneapolis, and Edna Peterson, San Francisco, trustees.

Gertrude L. Fife, retiring treasurer of the association and formerly director of the University Hospitals School of Anesthesia, Cleveland, received the association's 1950 award of appreciation at the annual banquet on September 20.

Health Plans Study Problems

NEW YORK.—The medical profession is trying to remedy three shortcomings in voluntary health insurance plans sponsored by the American Medical Association and its component medical societies, Dr. Louis H. Bauer, chairman of the association's board, stated here last month. Dr. Bauer said the three remaining lacks in the voluntary program were its failure to provide for individual instead of group enrollment, lack of protection of persons over 65 years of age, and failure to protect adequately against long-term or "financially catastrophic" illness.

Dr. Bauer said that 70,000,000 people are enrolled in Blue Cross and other voluntary health insurance programs.

Convalescent Hospital Features "Woman's Touch"

DAYTON, OHIO.—The Barney Convalescent Hospital at North Dayton, a 50 bed institution devoted primarily to the rehabilitation of crippled children, was opened here last month, Mrs. Aurelia Porter, hospital director, reported. The institution was financed by gifts to a community center fund here.

Said to feature the "woman's touch," the hospital is attractively decorated in colors to eliminate the institutional atmosphere with decorative elements planned to interest child patients.

Medical Grievances Aired

CHICAGO.—Medical societies of 34 states have established grievance committees for handling patients' complaints, Dr. George F. Lull, secretary of the American Medical Association, reported here last month. Dr. Lull said patients who feel doctors have overcharged them are invited to present their complaints to these grievance committees. No doctor has refused to accept the recommendation of such a committee, he added. Most complaints result from misunderstanding, the grievance committees have discovered.

The statement below* on Contour Sheets was submitted to a group of hospital users picked at random from our files. We told them frankly we wanted to use it in advertising, asked them to read it carefully and return it with their comments. They not only agreed with it, they told us we were too conservative. We were amazed at their enthusiasm. You'll be amazed at Contour Sheets.

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- **Save Nurses' Time**
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Read the above statement over again, one clause at a time—*"wrinkle free"—"stay smooth"—"save time"—"cut costs."* Strong statements! Yet each individual clause, based on fact and experience, has not only been corroborated but corroborated *enthusiastically* by hospital personnel — superintendents, purchasing agents, supervisors, housekeepers, nurses, laundry managers. Under the circumstances, don't you think you should try Contour Sheets in your hospital?

Contour Sheets for Hospital Mattresses, made by Pacific Mills, are nationally distributed by

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NEWS...

Registration of Doctors and Dentists Ordered

WASHINGTON, D.C.—Registration of physicians, dentists and veterinarians below the age of 50 not now serving in the armed forces or reserves and not having 21 months of active duty was ordered last month by Presidential proclamation. Registration of the group subject to prior call under the "doctor draft" law passed last September was carried out on October 16. The first group included those who received professional training in army or navy programs and were deferred as students during World War II.

The President's proclamation called for completion of registration for the "under 50" group by January 16, and authorized selective service headquarters to fix dates for registration of groups not registered in the October 16 draft.

Malheur Memorial Opens

NYSSA, IDAHO.—The Malheur Memorial Hospital was opened here last month following four years of public fund-raising organization and construction effort. John O'Toole is administrator of the hospital which will serve an area covering several counties in southern Idaho and eastern Oregon, it was explained. Mr. O'Toole was formerly administrator of a proprietary hospital in California.

The $360,000 project was financed entirely through voluntary donations of residents of the district, Harold Henigson, a member of the founders' committee, said. The hospital was built without federal aid. It was offered but refused by the residents' group, he stated.

The hospital has 44 beds.

Hayden Deaner Elected President of N.U. Alumni

CHICAGO.—Hayden M. Deaner, administrator of the Truesdale Hospital at Fall River, Mass., was named president of the alumni association of the program in hospital administration at Northwestern University, it was announced at the university here last month. The association's annual meeting was held at Atlantic City at the time of the American Hospital Association convention.

Other officers named by the alumni group were: president-elect, Ray K. Bolinger, Sayre, Pa.; vice president, James R. Gersonde, Chicago; secretary, William R. Williams, Chicago; treasurer, John P. Garrison, Winona, Minn.; board member, Marjorie Sanders, Flint, Mich.

Nurses Want Representation on Planning Committees

CHICAGO.—The nursing profession is entitled to representation on state hospital planning and advisory committees, Elizabeth Porter, president of the American Nurses' Association, said at a recent conference of state nurses' association secretaries here. Twenty-two states have nursing representatives on hospital advisory committees, Mrs. Porter said. She stated that such representation should be provided in every state since "nursing care is the major service provided by hospitals."

Plans for the extended nationwide study of nursing functions initiated by the A.N.A. house of delegates at its San Francisco meeting last May were described by Elizabeth LaPerle, A.N.A. consultant on nursing statistics and research.

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Take for instance the fire that put the x-ray department of a Long Island hospital out of commission . . . damaging beyond repair their diagnostic x-ray panel. Prepared for any contingency, the hospital pressed a mobile unit into action and called GE X-Ray service.

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NEWS...

No Additional Facilities for Maternity Cases Needed in New York, Council Says

NEW YORK.—New York does not need additional hospital facilities for maternity care, the Hospital Council of Greater New York announced here following a survey of needs and facilities in this classification. The council pointed out that the city birth rate has declined steadily in the last two years, and it estimates that the decline will continue.

There were 4514 beds in 103 hospitals providing obstetrical service in the city during 1949. The council found 4290 of this number were in use during the year.

"In view of the experience in recent years, and the likelihood of fewer births in the next several years, it appears that the obstetrical service in New York City is at least adequate," the council stated. The geographical distribution of beds in various areas of the city, however, it was pointed out, was not proportionate to the need in every case.

N.Y.C. Voluntary Hospitals Cooperating, Dr. Kogel Says

NEW YORK CITY.—A reported statement that hundreds of beds were idle in voluntary institutions while city institutions faced serious overcrowding has been described here as "confused and garbled half truths" by Dr. Marcus D. Kogel, city hospitals commissioner. The report had been made at a meeting of the State Charities Aid Association.

Dr. Kogel said voluntary hospitals, through the Greater New York Hospital Association, were making as many beds as possible available. An appeal from the department of hospitals had been received sympathetically by the voluntary hospitals, he said, and additional facilities were being made available daily. Dr. Kogel described the statement that many beds in voluntary hospitals might be used by the city as "without foundation in fact."

Plan Expansion at Aultman

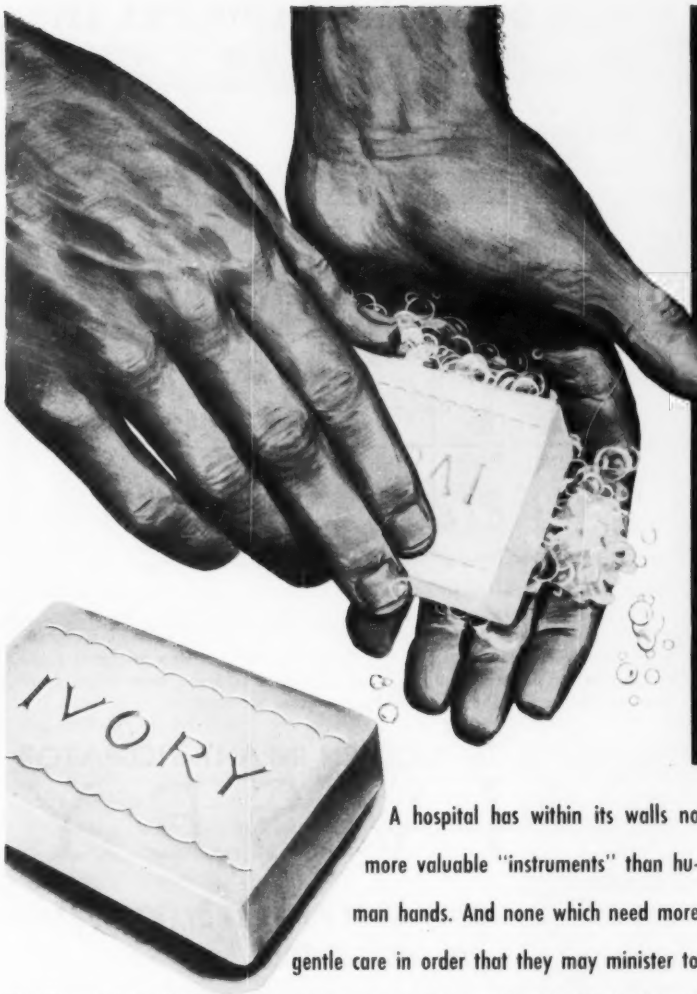
CANTON, OHIO.—Construction was undertaken late last summer on a $2,000,000 wing for the Aultman Hospital, it has been announced here. The addition will provide space for 200 more beds and other needed facilities, increasing the hospital's capacity to more than 500 beds, it was explained.

The new building will also include space for operating rooms, administrative offices, service space and outpatient facilities, the hospital stated. In a separate building project, an addition to the nurses' home will be constructed. Funds for the new construction were provided in a $2,000,000 campaign conducted for the hospital by Ketchum, Inc.

Urges Improvement in Treatment of Aged

NEW YORK.—General hospitals have neglected their responsibility toward aged and chronic patients, Dr. Martin Steinberg, executive director of Mount Sinai Hospital, charged in an address to the American Geriatric Society here recently. Dr. Steinberg said general hospitals are "very grudging" in offering service to older persons.

General hospitals commonly classify aged patients as bad risks without investigating individual cases carefully enough, Dr. Steinberg stated, and nurses frequently complain about having to care for older patients.



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Today's Ivory is a finer soap than ever before. Ivory now lathers faster and more richly in either hot or cold water. The gracefully designed cakes are handsomer and easier to handle. And today's Ivory — as in the past 70 years — costs surprisingly little for a soap of such fineness.

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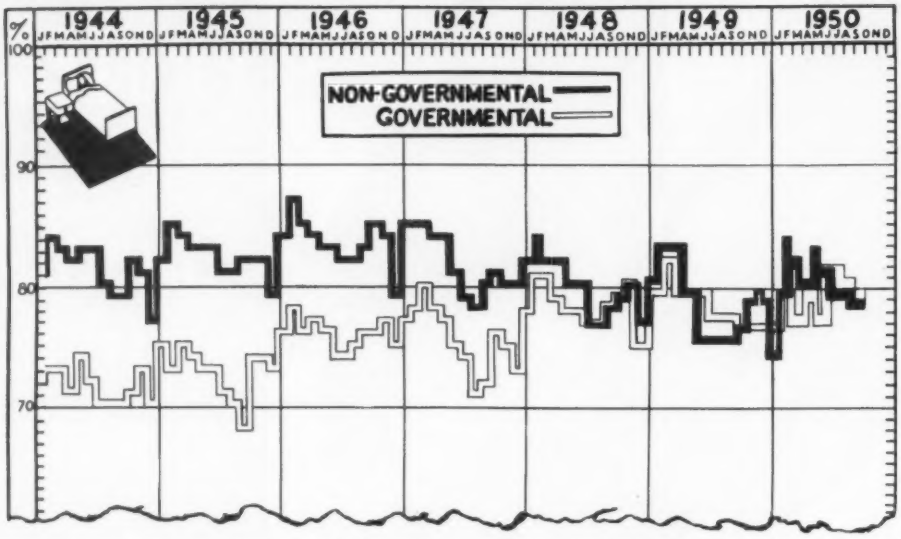
Ivory Soap is available for hospital use in the popular unwrapped 3-ounce size, as well as in smaller sizes—wrapped or unwrapped.

Construction for Year-to-Date Reaches $719,725,311



As reported to the Occupancy Chart, voluntary hospitals remained at something less than peak occupancy in September, with 78.8 per cent of capacity reported by hospitals in this group, about the same as the occupancy reported for the three previous months. Governmental hospitals reported 80 per cent occupancy for the same period—a slight decrease from last month.

Construction projects reported for the latest period totaled $38,910,000 which brings the total for the year to date to $719,725,311. Of 49 projects reporting costs, 19 were new hospitals, costing $17,941,080; 28 were additions, costing $18,059,082, and 2 were nurses' homes, costing $536,000.

What about Deliveries of SIMMONS Hospital Products?

Ever since the end of World War II, hospitals in all parts of the country have demonstrated their preference for Simmons hospital furniture and equipment by a constant increase in orders.

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Then came the Korean War!

Hospitals, anticipating restrictions and shortages, turned their plans for purchases into actual orders.

Overnight Simmons' business increased tremendously. In one month alone, orders for metal furniture were more than three times normal! Naturally, delivery dates for these orders had to be extended.

At the same time, an increasing number of war casualties demanded extra beds immediately for military hospitals. They were supplied even though it meant disruption of orders already on the books.

Now Simmons goes all out to meet demand

To meet this vast increase in orders, production schedules were again stepped up. To help fill the demand for hospital furniture, materials were diverted from consumer products.

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↓ **Armstrong's Linoleum** is a moderately priced flooring with a number of advantages which recommend it for use in hospital corridors. It is long wearing even under heavy traffic, quiet and comfortable underfoot, and especially easy to keep clean. Also, the wide variety of colors and patterns available in this flooring give many opportunities to add to the hospital's appearance.

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IN every hospital, floors serve a wide variety of needs and are exposed to varying service conditions. Armstrong's Linoleum is widely used for private rooms and wards because of its moderate cost and its ability to withstand hard wear. Where cost is the major factor, Armstrong's Asphalt Tile is often selected because of its low first cost. In addition to its economy, Armstrong's Asphalt Tile is long wearing and is unusually attractive. Armstrong's Cork Tile is ideal for special areas where restful quiet is desired. The unusual durability and beauty of Armstrong's Linotile® and Rubber Tile make them the best choice for main lobbies and corridors. Where floors are in direct contact with the ground, Armstrong's Asphalt Tile is recommended because of its alkaline resisting qualities. Before selecting any resilient floor, call in your Armstrong flooring contractor. He'll help you select the Armstrong Floor best suited to your needs.

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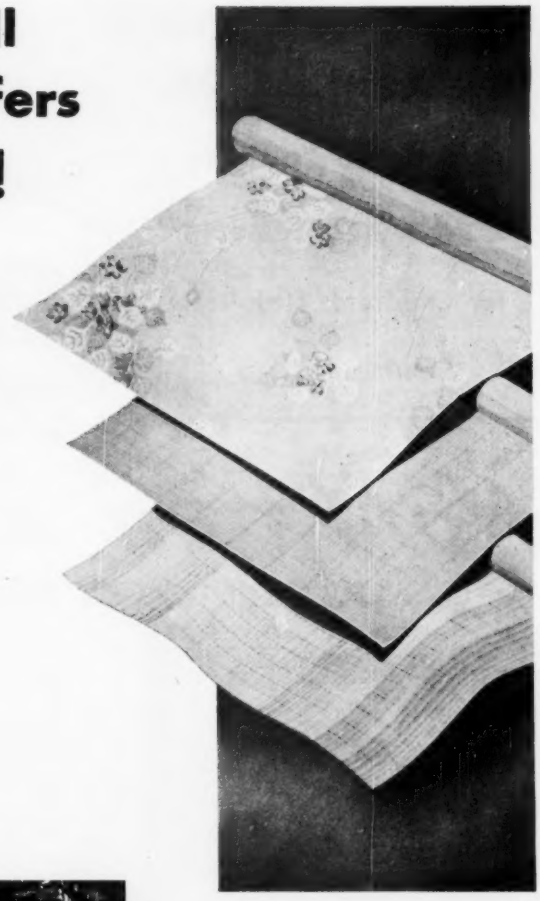

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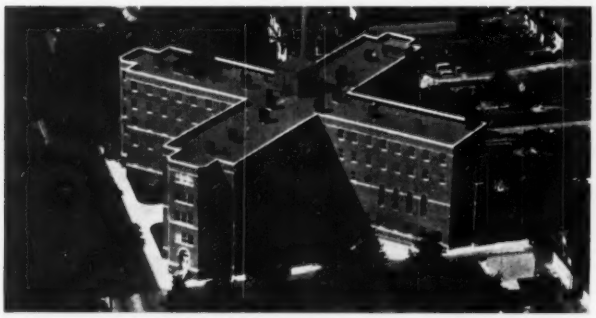

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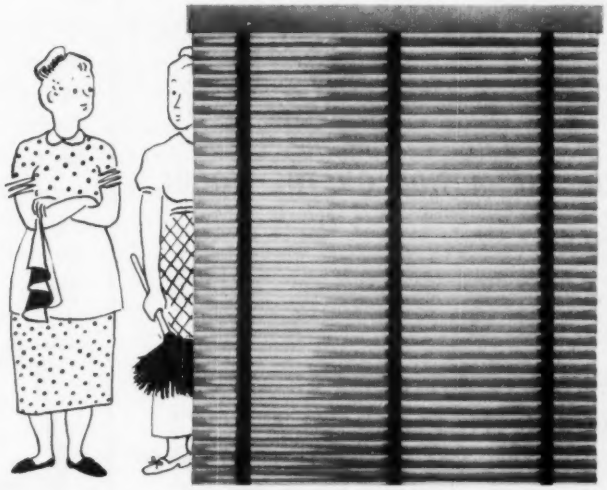

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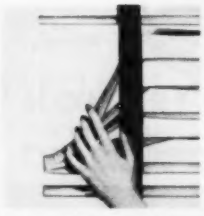
That's the maintenance secret! No hours wasted scrubbing: a damp cloth does the job perfectly in seconds! No money wasted replacing worn-out tapes, either: Flexalum tape keeps its looks in spite of weather and wear, won't fade, shrink, stretch, fray, or mildew. The one tape that belongs at business windows is Flexalum—the tape that's built to stand abuse!



EXCLUSIVE SNAP-BACK SLATS!

Supple aluminum slats spring-tempered by a process exclusive with Hunter Douglas—the only slats that snap back to perfect shape when bent to a 90° angle at the route hole! Baked-on finish won't chip, crack, peel, rust; sheds dirt quickly. Maintenance and repair costs slashed to minimum! Only Flexalum slats with the visible-invisible trademark can offer you all these features.

Write for maintenance booklet See Flexalum Specifications in Sweet's File Architectural Section $\frac{19e}{Hu}$ Builder's File $\frac{3g}{Hu}$

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WELDWOOD FIRE DOOR

This *wood-faced* fire door has the Underwriters' Label for Class "B" openings. Use it with absolute assurance anywhere specifications call for this type of door. Incombustible Kaylo core, with special construction and fireproofed edge banding, combines with beautiful hardwood facings to give you a door that decorates as well as protects. These labeled doors are available with or without a 10″x10″ light opening, in widths up to and including 4′.

WELDWOOD STANDARD KAYLO CORE DOOR

Similar to the Weldwood® Fire Door, but without the fireproofed edge banding. This door does *not* have the Underwriters' Label, but the incombustible Kaylo* core gives it a high degree of fire protection. It is recommended for use where a labeled door is not specified, but where fire resistance is a desirable extra advantage. Same wide variety of beautiful hardwood facings . . . imported and domestic . . . to choose from.

**Reg. Trademark, Owens-Illinois Glass Co.*

and both doors give you these advantages

1. *Remarkable dimensional stability.* The Weldwood Fire Door is guaranteed against warping, swelling or shrinking under any ordinary service conditions.
2. *Unusual Strength and Durability* . . . will withstand years of hard service.
3. *Vermin and Decay Proof* . . . permanently resistant to fungus, decay and termites.
4. *High Insulating Value.*

Read this remarkable service record

The photograph at the right shows a Weldwood Standard Kaylo Core Door that was installed in the Sodus School, Sodus, N. Y. It has been through a serious fire. Although flames raged all around it, the door is unwarped. Except for superficial damage to appearance, it's in perfect working condition.

Another Weldwood door in the same installation stood for a protracted time in ¾″ of water, yet the veneer showed no sign of loosening. Still another had the veneer burned off and the glass broken by heat, yet there wasn't a bit of warpage.

And, remember, this is the record of *Standard Kaylo Core Doors* . . . not the Weldwood Fire Door.

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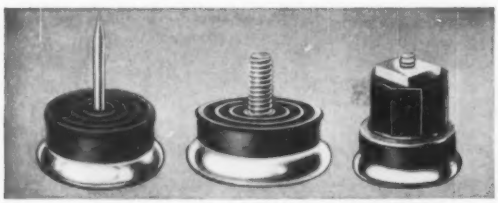

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We're so sure you'll find that Bassick's *best* for floor care, we say "Try these rubber cushion glides . . . on *us!*"

No finer, smoother-sliding glides at *any* price. And longer wearing, due to heavier gauge steel base with greater depth of hardening. THE BASSICK COMPANY, Bridgeport 2, Connecticut. Division of Stewart-Warner Corp. *In Canada:* Bassick Division, Stewart-Warner Corp., Ltd., Belleville, Ont.

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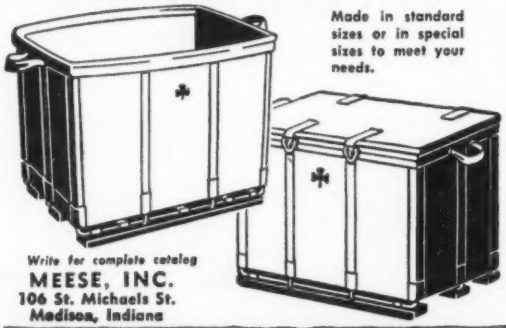

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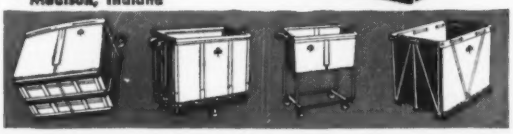

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*One of a series of reports on CORTONE**

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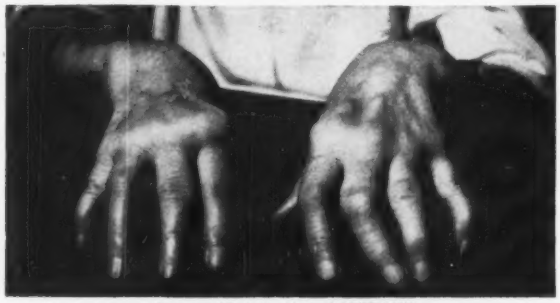
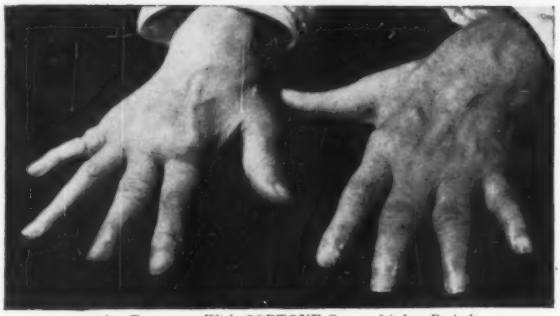


Prior to Administration of CORTONE



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History:
Disease present for eight years prior to administration of Cortone. Previous treatment included gold therapy, tonsillectomy, and general supportive measures.

Result:
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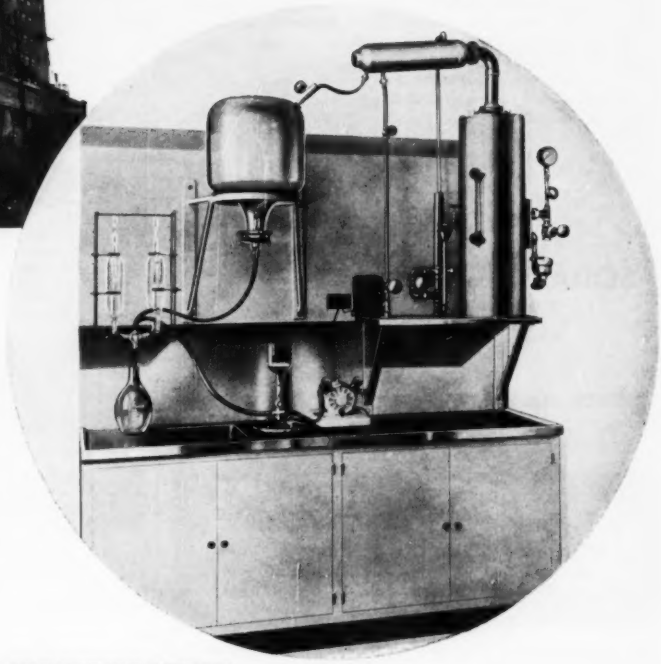

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not only offers unprecedented safety and economy in the preparation, sterilization, storage and administration of Sterile Solutions . . . a major part of its component elements are actually essential to the blood bank facility as well.

Nationwide hospital experiences substantiate the consistent degree of accuracy and safety attainable by any properly trained attendant . . . far less difficult than that of collecting blood and producing plasma. Hospitals, large or small, can benefit by this timely installation . . . only negligible space is required.

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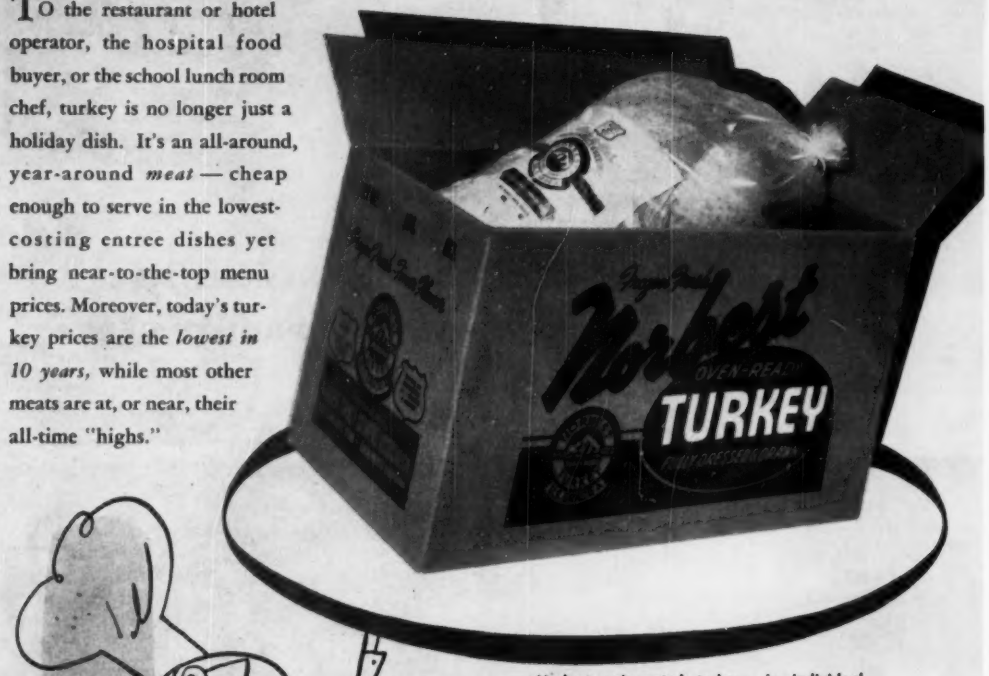
To the restaurant or hotel operator, the hospital food buyer, or the school lunch room chef, turkey is no longer just a holiday dish. It's an all-around, year-around *meat* — cheap enough to serve in the lowest-costing entree dishes yet bring near-to-the-top menu prices. Moreover, today's turkey prices are the *lowest in 10 years,* while most other meats are at, or near, their all-time "highs."



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Here is the pick of the flock from thousands of Western turkey farms, who sell through America's largest grower-owned turkey marketing organization. Every Norbest turkey is a U. S. "A" Grade tender young bird of highest quality. Available in individually packed cartons, or in case or carlot orders from coast to coast.

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Want Advertisements

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CHEMIST—Clinical; B.S., CH.E., M.A., Ph.D., national reputation; topflight organizer; experienced hospital biochemist and university professor; over 80 publications; at present in charge of an active laboratory employing a staff of 20; seeks connection with an institution interested in developing a dynamic modern division of clinical chemistry. MW 22, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIETITIAN—Administrative; A.D.A. member; sixteen years' experience as department head; central middle west location desired; available immediately. MW 20, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

LIBRARIAN—Registered record; experienced, mature; desires position in 100-200 bed hospital; maintenance preferred but not essential; Missouri, Illinois, Florida; available, January. MW 19, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISOR—Night; registered nurse seeks position in hospital of 90-100 beds; superintendent of small community hospital for several years; available in 60 days. MW 21, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

INTERSTATE HOSPITAL AND PERSONNEL BUREAU

Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR—B.B.A. Degree, midwestern university; majoring in finance, and public relations; member, A.C.H.A.; 9 years' administrator, 85-bed Michigan hospital; 2 years' director, well known private clinic.

ADMINISTRATOR—R.N., B.S. Degree, Columbia University; Fellow, A.C.H.A.; 10 years' director of nursing; 15 years' administrator, 120-bed hospitals, Pennsylvania, Indiana, Florida.

BUSINESS ADMINISTRATOR—B.S. Degree, Business Administration, University of North Dakota; 1 year's administrative internship; 3 years' business manager, 120-bed hospital, midwest.

ADMINISTRATOR—LL.B. Degree, southern university; 9 years' personnel manager and office manager; 3 years' administrator, 65-bed hospital, Tennessee; prefers south or southwest.

THE MEDICAL BUREAU

Burneice Larson, Director
Palmolive Building
Chicago 11, Illinois

ADMINISTRATOR—A.B., Majors, Economics, Accounting; B.S. Institutional and Hotel Administration, Cornell; M.S., Hospital Administration; three years, assistant administrator, 500-bed teaching hospital; eight years, administrator 275-bed hospital; member ACHA.

ADMINISTRATOR—Medical; degrees eastern universities; two years' graduate training in public health medicine; three years, assistant

MEDICAL BUREAU—*Continued*

administrator, 600-bed municipal hospital; seven years, director, voluntary hospital 500 beds affiliated with university medical school; FACHA.

ADMINISTRATOR—A.B., eastern university; year's graduate work, sociology, statistics, Harvard; M.S., Hospital Administration, Columbia; year's administrative internship; three years, assistant administrator, 500-bed hospital; prefers directorship hospital of 100-150 beds or assistantship in larger one.

ADMINISTRATOR—Registered nurse; Degree in Hospital Administration; year's hospital administrative residency; two years, administrator, 65-bed hospital; prefers administratorship, hospital not over 100 beds.

ANESTHESIOLOGIST—Now in process of completing certification; training received in university medical center; eight years, private practice of anesthesiology and director of department anesthesiology, 200-bed hospital.

DIRECTOR OF NURSES—B.S. Yale University; graduate training, nursing education, child development; three years, operating room supervisor, large teaching hospital; seven years, director of nursing, teaching hospital.

PATHOLOGIST—Diplomate, American Board; FCAP; four years, department of pathology, university medical school; eleven years, director of laboratories, 375-bed hospital; associate professor pathology university medical school and director of pathology 500-bed teaching hospital.

RADIOLOGIST—Diplomate, American Board in Diagnosis, Therapy and Radium Therapy; training received at university medical center; teaching experience, four years, director of radiology, 250-bed hospital.

OPERATING ROOM SUPERVISOR—Postgraduate training in operating room technique, university center; 14 years' experience; past 5 years, supervisor 400-bed teaching hospital.

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ADMINISTRATOR—Lay: FACHA; university graduate training in accounting, personnel, public speaking; post graduate work in hospital administration; experience includes 3 years, director, State Hospital Care Plan; 4 years, 400-bed southern general hospital; 4 years, administrator, 500-bed, important general hospital; member, House of Delegates of the American Hospital Association; interested hospital, 300 beds, up; early forties; available reasonable time.

GROUP-CLINIC ADMINISTRATOR—Well experienced in contracts, accounting, credit and collection controls, personnel management, both professional and lay, various forms of income distribution, corporation work in connection with partnerships, taxes; currently administrator, exceptionally large group of doctors covering all specialties and non-professional staff of 50; middle forties, dignified, charming personality, immediately available.

WOODWARD—*Continued*

ADMINISTRATOR—Medical; B.S., M.D. state university; 3 years, assistant administrator, large teaching hospital; seven years, director, 400-bed voluntary hospital; FACHA; interested hospitals 250 beds, up; immediately available.

PHYSICIAN—Well trained in tuberculosis, anethesiology and public health; several years' as tuberculosis consultant, State Board of Health; 3 years' institutional work as medical director and superintendent; late thirties; immediately available.

RADIOLOGIST—Certified in diagnostic and therapy; experience includes several years, private practice of roengenology; 4 years, consulting roengenologist, United States Navy and, also, roengenologist, large eastern hospital; currently, chief of radiology, veterans hospital; immediately available.

PATHOLOGIST—Certified; early forties; 6 years' residency training in pathology, large teaching hospital; 3 years, assistant pathologist, 300-bed Ohio hospital; past 3 years, director of laboratories, 3 medium size hospitals; interested in teaching; available, 6 weeks.

EXECUTIVE HOUSEKEEPER—About 8 years' assistant housekeeper, 700-bed teaching hospital; past several years, executive housekeeper, 350-bed general hospital; member, NEHA; late thirties.

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POSITIONS OPEN

ANESTHETIST—Nurse; for 300-bed hospital; four anesthetists now on service; salary open. Apply, D. W. Hartman, Superintendent, The Williamsport Hospital, Williamsport, Pennsylvania.

ANESTHETIST—For modern 250-bed general hospital; no maternity; starting salary $325; increase semi-annually; two meals and laundry. Apply Superintendent, Sutter Hospital, Sacramento, California.

ANESTHETIST—Nurse; for 100-bed general hospital in northeastern Minnesota; two anesthetists employed; $350 and maintenance. Apply John M. Alexon, Administrator, Municipal Hospital, Virginia, Minnesota.

ANESTHETIST—Registered nurse; small modern hospital; college town; excellent salary, plus full maintenance; unusually good working conditions. Apply Administrator, Centre County Hospital, Bellefonte, Pennsylvania.

DIETITIAN—Registered; wanted for a fully approved 150-bed hospital; good salary and pleasant surroundings. Apply Mother Marie, Maryview Hospital, Portsmouth, Virginia.

DIETITIAN—Teaching; for a 290-bed hospital with a school of nursing. Write Superintendent, Borgess Hospital, Kalamazoo, Michigan.

Terms: 20c a word—minimum charge of $4.00 regardless of discounts. No charge for "key" number. Ten per cent discount for two or more insertions without changes of copy. Forms close 15th of month.

(Continued on page 216)

Want Advertisements

POSITIONS OPEN

DIETITIAN—ADA; small modern hospital; college town; excellent salary, plus full maintenance; good working conditions. Apply Administrator, Centre County Hospital, Bellefonte, Pennsylvania.

DIETITIAN—Qualified; position now open; new 120-bed hospital to be started soon. For information apply, Superintendent, Charlotte County Hospital, St. Stephen, New Brunswick.

DIETITIAN—Therapeutic; 300-bed approved general hospital, in central Pennsylvania. Apply, D. W. Hartman, Administrator, The Williamsport Hospital, Williamsport, Pennsylvania.

DIRECTOR—Educational; for progressive 100-bed general hospital with 50 student nurses; attractive personnel policies; salary open, depending upon experience and qualifications; maintenance. For further information write, Director of Nursing, Lutheran Hospital, Vicksburg, Mississippi.

DIRECTOR OF NURSES—230-bed hospital, western Pennsylvania; 75 students in school; minimum requirements, B.S. in Nursing Education; some experience. Apply, Superintendent, Westmoreland Hospital, Greensburg, Pennsylvania.

INSTRUCTOR—Assistant clinical; for 192-bed general hospital; student enrollment 75; medical surgical nursing, qualified to teach pharmacology; salary open; Position available now. House of the Good Samaritan, Watertown, New York.

INSTRUCTOR—Science; for 192-bed general hospital; fall enrollment 25-30; subjects, anatomy and physiology, microbiology; salary open; position available now. House of the Good Samaritan, Watertown, New York.

INSTRUCTORS—Science; excellent opportunity; clinical; immediate vacancy; for approved school of nursing; 400-bed general hospital, vacation and sick leave policy. For details, apply Personnel Director, The Christ Hospital, Cincinnati, Ohio.

INSTRUCTORS—Science and Clinical; for accredited school of 50 students; new educational unit under construction to be supplied with all modern teaching equipment; liberal personnel policies; 44-hour week; salary $3360 to $3600, depending on experience, less $50 a month maintenance. Apply, Directress of Nurses, Lock Haven Hospital, Lock Haven, Pennsylvania.

INTERNSHIP OR GENERAL RESIDENCY—Available immediately, at City Hospital, Brunswick, Georgia; 100-bed capacity with provisional ACS approval; full maintenance plus $200 per month salary.

LIBRARIAN—Record; 300-bed approved general hospital, in central Pennsylvania. Apply D. W. Hartman, Administrator, The Williamsport Hospital, Williamsport, Pennsylvania.

LIBRARIAN—Record; for 95-bed hospital; salary, $290; maintenance available; 41½-hour week; travel expense refunded at end of 18 months of service. Apply, Wilcox Memorial Hospital, Lihue, Kauai, Hawaii.

MISCELLANEOUS—Nursing arts instructor; Educational director; Operating room supervisor, needed at once; immediate opening; good location; State Capitol with many civic advantages; salary open. Apply Director of Nurses, Evangelical Hospital, 6th and Thayer, Bismarck, North Dakota.

MISCELLANEOUS—One Supervisor and one General duty nurse; meals while on duty and laundry of uniforms. Apply Business Manager, Floyd County Co-Operative Hospital; Lockney, Texas.

MISCELLANEOUS—Anesthetist and experienced Laboratory technician; immediately; highest salary and pleasant working conditions with most modern equipment. Applicants apply, Mrs. Bennett, Superintendent, The Lynn Hospital, 2950 South Fort Street, Detroit 25, Michigan.

MISCELLANEOUS—New 130-bed hospital will need a Director of nursing, ADA Dietitian, Nurse anesthetists, Registered record librarian, in Spring 1951. Contact, Pat N. Groner, Administrator, Pensacola Baptist Hospital, Pensacola, Florida.

NURSE—Suture; $250 per month plus full maintenance; no night calls; western Pennsylvania college town. MO 98, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSE—General duty; northwest; salary $200 with complete maintenance. Apply, Superintendent, State Sanatorium, Basin, Wyoming.

(Continued on page 218)

Want Advertisements

POSITIONS OPEN

NURSES—General duty; for 360-bed general hospital; starting salary $175 per month with maintenance; $200 per month with partial maintenance; rotating shifts; two weeks' vacation; 30 days' sick leave; 6 holidays yearly with pay; 44-hour week; college courses available through night classes at local university. Apply Director of Nursing, Greenville General Hospital, Greenville, South Carolina.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary $200 to $210 month; full maintenance available for $10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

NURSES—Staff; for pediatric hospital; salary, $210 for 40-hour week; liberal personnel policies. Apply Superintendent, Doernbecher Hospital, Portland, Oregon.

NURSES—General duty—Scrub nurses; 3; salary $200; extra remuneration for call; permanent night nurses for medical and surgical wards; 2; salary $215 meals and laundry in addition to salary quoted; 44-hour week; $10 increase after 60 days; living accommodation if desired, attractive new nurses residence to be opened in November; 210-bed general hospital in residential suburb of Chicago. Apply to Director of Nursing, MacNeal Memorial Hospital, 3249 S. Oak Park Avenue, Berwyn, Illinois.

NURSES—Supervisors and General staff; all shifts, new modern excellently equipped hospital; 78-bed; open in October 1950; exceptional living accommodations available. Director of Nurses, Pioneers Memorial Hospital, P.O. Box 1141, Brawley, California.

NURSES—Registered; for staff duty; 44-hour week, mealtime included; $180 maintenance without room; $145, complete maintenance; increase $60 annually after six months and one year; $5 extra for evening and night; $10 for operating room. Episcopal Eye, Ear and Throat Hospital, Washington 5, District of Columbia.

NURSES—General duty; for 7 A.M. to 3 P.M.; 3 P.M. to 11 P.M.; 11 P.M. to 7 A.M., tours of duty; excellent personnel policies. Applications should be addressed to Director of Nurses, Corning Hospital, Corning, New York.

NURSES—Graduate; staff; full or part time in 390-bed hospital connected with medical school; positions open in medical, surgical, pediatric, gynecologic and obstetric departments and in the operating room; constantly expanding facilities; 44-hour week; salary range $200-$215 per month for nurses who can rotate on day, evening, and night duty; exceptional opportunity for furthering education in Vanderbilt University. Write Director of Nursing Service, Vanderbilt University Hospital, Nashville, Tennessee.

NURSES—General duty; new 26-bed hospital; opportunity for 2 general duty nurses interested in anesthesia or surgical nursing; minimum $225 to start, more depending on experience. Apply Heron Lake Hospital, Heron Lake, Minnesota.

(Continued on page 220)

NURSES—General duty; for 147-bed hospital; salary $215 per month with $10 differential for evening or night duty; also Surgery scrub nurse; $235 per month. Apply, Mrs. Ruth Garland, R.N., Superintendent of Nurses, Memorial Hospital of Natrona County, Casper, Wyoming.

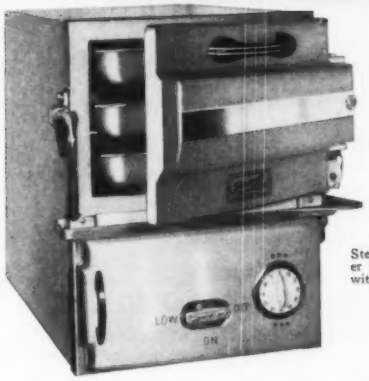
NURSES—Head; for 46-bed obstetrical floor and 29-bed communicable disease ward; also general staff nurses for medicine, surgery, obstetrics, nursery and operating room; 44-hour week; 4 weeks paid vacation. Apply Director of Nursing, Evanston Hospital, Evanston, Illinois.

NURSES—Registered; for general medical, surgical and obstetrical services; also supervisory nurses in 80-bed hospital. For more information write the Director of Nurses, East Side General Hospital, 2199 Cadillac Boulevard, Detroit 14, Michigan.

NURSES—Surgery; northern Illinois; 30-bed hospital; salary $220 with meals; two weeks' paid vacation; 45-hour week, on call 5 nights; experience not required if desire an aptitude; also General duty nurses; 3-11 and 11-7, 5 days, $195. Call or write Superintendent, Woodward Memorial Hospital, Sandwich, Illinois.

SUPERVISOR—Operating room; for 150-bed general hospital school of nursing; advanced preparation and experience desired; 44-hour week; teaching responsibilities; salary open but commensurate with ability and training. Write, Director of Nurses, Bryan Memorial Hospital, Lincoln, Nebraska.

Yes - Steam Cookers are Now Made for SMALL KITCHENS



Steamcraft Cub counter model. Also comes with base.

Here's the answer to the question which many food service operators have been asking. It's true —there IS a low-cost line of small steam cookers available for the needs of *any* size establishment! They are called *Steamcrafts*, and operated by direct steam line, gas, or electricity. They are furnished in 1 or 2 compartment sizes, with base or for use on your own table or counter. They hold 3 full size or 6 half-size cafeteria pans per compartment. They can be had with fully automatic heat controls, or clock timers, or manual controls. All have self-acting water feeds—no hand filling. They require minimum installation cost and operate with phenomenal fuel economy.

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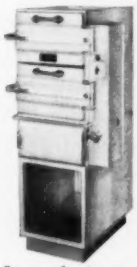

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TECHNICIAN—X-ray and laboratory combined; salary $250 with complete maintenance. Apply, Superintendent, State Sanatorium, Basin, Wyoming.

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ASSISTANT MEDICAL DIRECTORS—(a) 185-bed eastern tuberculosis sanatorium. (b) 165-bed hospital for chronic diseases; northeast. (c) 400-bed general teaching hospital; mid-west.

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DIRECTORS OF NURSING—(a) 300-bed hospital, southern medical center: $5000, maintenance. (b) 175-bed hospital, Virginia; $375. (c) 200-bed hospital; school with university affiliation; west; $4200, plus apartment. (d) 150-bed hospital, Pennsylvania.

SCIENCE INSTRUCTORS—(a) 200-bed teaching hospital; northwest; $300. (b) 180-bed hospital, South Carolina. (c) 165-bed hospital, Ohio.

(Continued on page 222)

INTERSTATE—Continued

EDUCATIONAL DIRECTORS—(a) 175-bed hospital; new educational unit; ideal working conditions; $300, maintenance; east. (b) 200-bed hospital, south; open January. (c) 335-bed hospital, affiliated with western university.

DIRECTORS, NURSING SERVICE—(a) 100-bed new hospital, western resort city. (b) 125-bed new hospital, to be opened in January; New England. (c) 100-bed modern hospital, Virginia.

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EXECUTIVE HOUSEKEEPERS—(a) 350-bed hospital, east. (b) 175-bed Pennsylvania hospital. (c) 135-bed hospital, near Chicago. (d) 125-bed hospital, Ohio. (e) 100-bed hospital, southwest; $275.

DIETITIANS—Therapeutic; $185-$225, maintenance; attractive localities.

Want Advertisements

POSITIONS OPEN

INTERSTATE—*Continued*

ADMINISTRATIVE DIETITIANS—(a) 170-bed hospital, South Carolina; $275, maintenance. (b) 250-bed hospital, near Washington, District of Columbia. (c) 160-bed hospital, Ohio.

TECHNICIANS—X-ray: $175-$200, maintenance.

TECHNICIANS—Laboratory: $200-$300.

RECORD LIBRARIANS—(a) 150-bed hospital, Pennsylvania. (b) 300-bed hospital, New York; (c) 100-bed Ohio hospital. (d) 125-bed hospital, Florida. (e) 115-bed mid-west hospital.

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ADMINISTRATORS—(a) Voluntary general hospital, 500 beds; university city of 200,000; much-sought-after location; minimum $15,000. (b) University hospital, 500 beds, adequately supported by patients' income, state appropriation; lay or medical. (c) City-owned hospital, 300 beds; non-political board; college town of 100,000; midwest. (d) Relatively new hospital, modern in every respect, 235 beds; well endowed, operating without state aid; residential town, short distance several large cities; east. (e) General hospital small size now under construction; completion expected January; east. (f) Medical; large general hospital; unit of university group; opportunity of directing entire group within several years. (g) Voluntary, general hospital; 350 beds; university city; west; member FACHA required. (h) General hospital, 100 beds; residential town short distance from university medical school; Pacific Northwest. (i) Assistant; Master's degree required; fairly large general hospital; college town, 50,000, east. (j) Assistant; although physician with formal training preferred, well qualified lay administrator eligible; large teaching hospital. (k) Assistant medical director; university group of hospitals; opportunity for obtaining excellent experience various phases of administration. (l) Medical director of large teaching hospital and vice president of medical college needs assistant; duties consist of assisting in college and hospital; formal training or experience unnecessary. MH 11-1.

ADMINISTRATORS—NURSES. (a) General hospital, 140 beds, relatively new; college town, east. (b) Small general hospital under construction, completion expected January; residential town short distance from university medical center; midwest. (c) Assistant; general hospital averaging 100 patients; opportunity of succeeding adminstrator upon retirement; college town of 50,000. MH11-2.

(*Continued on page 224*)

MEDICAL BUREAU—*Continued*

ANESTHETISTS—(a) Eminently successful group, staff of outstanding specialists, principally American Board men; residential town near university medical center; west; minimum $400. (b) Two; large teaching hospital; department directed by medical anesthesiologist, staffed by six medical resident anesthesiologists; university town, east. (c) Voluntary, general hospital, fairly large size; resort town, tropical islands; $3400-$4500. MH11-3.

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DIETITIANS—(a) Chief; fairly large general hospital, vicinity New York City. (b) Chief and assistant; 300-bed general hospital; college town, midwest. (c) Chief; new hospital, unit university group; west. (d) Chief and therapeutic dietitians; 400-bed hospital; university affiliation; southwest. (e) Assistant; duties include buying, supervising staff of twenty; 450-bed hospital; university town, midwest. MH11-5.

EXECUTIVE HOUSEKEEPERS—(a) General 500-bed hospital affiliated university medical school; east. (b) General 400-bed hospital; should be qualified to direct staff of sixty; midwest. (c) General 350-bed hospital relatively new; university town, southwest. MH11-7

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POSITIONS OPEN

MEDICAL BUREAU—*Continued*

DIRECTORS OF NURSES—(a) General 450-bed hospital; 200 students; $5000-$6000 complete maintenance; university center, south. (b) Voluntary general hospital, 350-beds; 130 students; university center; east. (c) One of the country's leading hospitals for children; 100 students, affiliates; university center. (d) New unit of university group; 300-beds; research institution in connection; west. (e) New hospital, staff of outstanding specialists; 175 beds, no school; town of 20,000 located in resort area of Pacific Northwest. (f) Director and assistant directors of nursing service; voluntary general hospital; fairly large size; fine school; resort town, tropical island. (g) One of leading hospitals on Pacific Coast; university affiliations; substantial salary including new penthouse apartment; university town. (h) To direct nursing services, two hospitals; no schools; town of 20,000, east. (i) Assistant director; Master's degree desirable; all-graduate staff; medical staff conducts teaching program approved by American Boards; university medical center; midwest. MH11-6.

EXECUTIVE PERSONNEL—(a) Chief accountant; 300-bed hospital, university medical center; midwest. (b) Purchasing agent; 350-bed hospital; university town of 200,000; delightfully equitable climate. (c) Personnel director; teaching hospital, 700 beds; man required. (d) Maintenance man; 200-bed hospital; university town, east. (e) Public relations director; professional organization; east. MH11-8.

MEDICAL BUREAU—*Continued*

FACULTY APPOINTMENTS—(a) Educational director qualified to serve as chairman of faculty council; 300-bed general hospital; New England. (b) Science instructor; general 200-bed hospital; school of 90 students; one working toward degree eligible; college town, 50,000, south; $3600. (c) Nursing arts instructor; three-year nursing program now being established by university; should be qualified to organize and equip nursing arts laboratory to be located on campus; faculty rank; minimum $4000. MH11-9.

PHARMACISTS—(a) Large general hospital located in leading city of United States dependency. (b) General 250-bed hospital operated by group clinic; university city, midwest. MH11-10.

RECORD LIBRARIANS—(a) Chief, qualified to re-organize and direct service in departments of three general hospitals, combined bed capacity 1200; large city, university center, midwest. (b) Chief; large general hospital; vicinity New York City. (c) To take charge of departments, small general hospital; one of islands in Pacific. MH11-11.

SUPERVISORS—(a) Operating room; 400-bed teaching hospital; staff of 70 specialists, 125 residents; service predominantly surgical; $5000. (b) Floor; preferably one qualified succeed lay administrator upon early retirement; general voluntary hospital, small size; fashionable winter resort town; south. (c) Obstetrical; department averages 800 deliveries annually; voluntary, general hospital, 400 beds; town, 50,000 located short distance from two university centers; south. (d) Orthopedic and

(Continued on page 226)

MEDICAL BUREAU—*Continued*

pediatric supervisors; children's unit university group; opportunity continuing studies. (e) Operating room; large general hospital; university city of 200,000; delightful climate; $3600-$4200. MH11-12.

TECHNICIANS—(a) Technologist to serve as chief; large teaching hospital; university center, midwest. (b) Chief x-ray technician; large, general hospital; east; $3000-$4800. MH11-13.

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POSITIONS OPEN

MEDICAL PERSONNEL EXCHANGE —*Continued*

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EXECUTIVE HOUSEKEEPER—Middle west: 200-bed modern hospital, fully approved; located in city of 31,000; department is well organized with a competent staff; $250 minimum to start plus full maintenance.

(Continued on page 228)

SHAY—*Continued*

DIETITIANS—Two; south; fully approved hospital, 114 beds; located in historic southern city of 35,000; have nurses training school; there are 3 other dietitians in department which is well organized; $300 minimum plus maintenance.

NURSE ANESTHETIST—East; general hospital, 150 beds; fully approved; located in a very lovely city of 30,000; excellent medical staff; equipment modern and living quarters are very pleasant; $400 plus full maintenance.

NURSE ANESTHETISTS—Middle west; 165-bed hospital located in city of 30,000 in heart of resort area; many facilities for both summer and winter sports; university located there permitting further education if desired; $350-$400 plus full maintenance.

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DIETITIAN—California hospital; $275.

Want Advertisements

POSITIONS OPEN

PHELPS—*Continued*

LABORATORY AND X-RAY TECHNICIAN—(a) Arizona; $250. (b) Laboratory technician; Oregon; $250.

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WOODWARD—*Continued*

(c) 140-bed hospital, industrial in character with excellent medical and administrative staff; southern town, 25,000; about $7000. (d) Assistant, medium size general now relocating in new 200-bed hospital on outskirts of large university medical center city; Administrative Degree preferred but not essential; should be church man; entire charge business office. (e) Small, new, modern in every respect; southern town, 5000; fairly uniform, temperate climate; consider woman. (f) General hospital of medium size just completing large addition; desirable western scenic section. (g) Small Arizona Indian general; newly furnished home. (h) Voluntary general of fairly large size under construction; attractive residential town, 14,000; east central.

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(Continued on page 230)

WOODWARD—*Continued*

ADMINISTRATORS—Nurse. (o) New small Alabama general; cooperative board; town, 5000. (p) Desirable smaller Indiana hospital to be enlarged; nice nursing staff and cooperative group of doctors; town, 9000; (q) Assistant, duties principally personnel and purchasing; will double present capacity in near future; large university and medical center. (r) New smaller midwest general, nearing completion; town, 5000; (s) New 40-bed general, opening soon; requires administrator now; attractive east central town of about 6000.

ADMINISTRATIVE STAFF APPOINTMENTS. (t) Business manager for new small community hospital; midwest town, 5000. (u) Chief accountant; large general hospital; university medical center city of large size; east-central. (v) Accountant for large clinic with fairly large hospital in midwest community, 25,000.

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(Continued on page 232)

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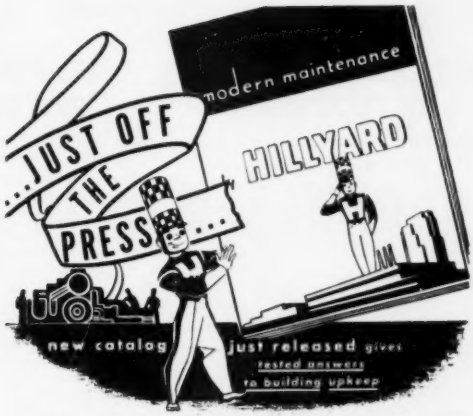

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J. G. JARRETT, Business Manager.

Sworn to and subscribed before me this 29th day of September, 1950.

[SEAL] J. P. McDERMOTT, Notary Public.

(My commission expires Sept. 29, 1953.)

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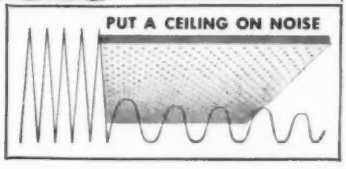


Johns-Manville

SANACOUSTIC CEILINGS

What's New for Hospitals

NOVEMBER 1950 Edited by BESSIE COVERT

Microfilm Reader

The new Model MPE microfilm reader is designed to project both 16 and 35 mm. negative or positive film, perforated or unperforated, and to give precision optical quality at a medium price. Magnification is 19 to 1. A scanning device allows the film to be moved laterally, so that images, the full width of film, can be projected. Any part of the record can be moved to the center of the screen for easier reading. Winding the film by a convenient hand crank provides scanning lengthwise of the film. Disc-like optical flats hold the images in sharp focus.

The 20 inch square screen is a reflecting type and is at desk level. The projector head has a rotating feature to permit the image always to be turned upright on the screen. The reader is slightly over 3 feet high, is designed for desk top use and is less than 2 feet square. It is made of sheet steel, finished in metallic gray and can be moved easily if desired. The Model MPE will be marketed as the Kodagraph Film Reader by Kodak dealers and as the Recordak Film Reader by Recordak Corporation. **Eastman Kodak Co., Dept. MH, Rochester 4, N. Y. (Key No. 794)**

Vitachrome Flooring

A new line of resilient tile flooring has recently been introduced under the name Vitachrome. It is a grease resistant, plastic-asbestos, resilient tile designed especially for use in cafeterias, kitchens and other food serving areas since it is not affected by animal and vegetable fats and has high resistance to alkali. Vitachrome is available in a wide variety of sizes and in 10 marbleized colors and 5 plain colors designed for feature strip and accent purposes. **The Tile-Tex Division, The Flintkote Co., Dept. MH, Chicago Heights, Ill. (Key No. 795)**

Oxygen Inlet

A new Oxygen Inlet has been designed for the Armstrong X-4 Baby Incubator to give the physician or nurse the opportunity to direct the flow of oxygen as desired. Thus almost any type of oxygen therapy may be employed. The new inlet also provides a slightly higher oxygen concentration with the same liter flow per minute.

The new Oxygen Inlet Nipple is in the lower corner of the left hand end of the incubator, shielded and protected. Inside the incubator is a diffusing shield that may be rotated to control the oxygen flow in any direction. **The Gordon Armstrong Company, Inc., Dept. MH, 1501 Euclid Ave., Cleveland 15, Ohio. (Key No. 796)**

Medicine Cup Dispenser

A low cost, wall mounted dispenser is now available for dispensing graduated, disposable one ounce medicine cups in hospitals. The unit is chrome plated and is operated in the same manner as dispensers for large paper cups. The medicine cup carton is inserted in the dispenser and as each cup is removed, another drops into place. **Ruby Products Co., Dept. MH, 430 N. Water St., Milwaukee 2, Wis. (Key No. 797)**

Flame Proofer

A new product is available for treating rugs, draperies and decorative fabrics to make them flame resistant. Known as the A. D. Flame Proofer, the product has had a year of research and testing which showed that the average char length of fabrics treated with it was only 3.9 inches. Fabrics which are not harmed by water can be treated through immersion with A. D. Flame Proofer. All others are sprayed with a fine spray under about 25 pounds' pressure to assure thorough penetration. A single treatment is effective for up to a year on garments and fabrics which are subjected to normal wear in an atmosphere of average humidity. Rugs, draperies, curtains and similar articles are said to be adequately protected when they are treated at intervals of approximately nine months. **Huntington Laboratories, Inc., Dept. MH, Huntington, Ind. (Key No. 798)**

Blood Bank Alarm

A small compact alarm which can be set on top of or near the Blood Bank Refrigerator has been developed. Known as the Tomac Alarm Box System, the alarm is set to ring when temperature rises critically (above 50 degrees) or falls below the safety point. It also rings if electricity is shut off. The alarm continues to ring until the temperature returns to safe levels. The alarm box is finished in white enamel and it is easy

to install. **American Hospital Supply Corp., Dept. MH, Evanston, Ill. (Key No. 799)**

Address manufacturers for further information and prices — or use Reader's Service blank on page 248

Edison Tele-Voicewriter

A new system for clinical recording which simplifies the procedure for the clinician as well as for the hospital has recently been introduced. Known as the Edison Tele-Voicewriter, the system provides dictating facilities in several spots in the hospital where the physician might use them, thus assisting the hospital to secure complete, detailed medical records. The Edison Phones are installed in strategic locations, even in treatment and examining rooms so that the doctor needs merely to pick up the 'phone and dictate his report which is recorded in a central location. The system is so designed as to be foolproof since signal lights and other indications prevent more than one doctor dictating into one central machine at the same time.

The recording instrument or instruments may be located in or near the Medical Record Library or other central station. One or more of the central recorders, or Tele-Voicewriters, are connected to a number of Edison Phones. The design of the Edison Phones is based upon the telephone extensions of either the desk or wall type and doctors need practically no instructions to use the system. The doctor automatically indicates the length of his report, where corrections occur and may listen back to previous dictation if desired. Having the Edison Phones readily available to the doctor where he is working and the ease with which records can be dictated are inducements to the doctor not to delay medical records. The material is dictated to the desk of the secretary for transcription without transportation of the actual recorded matter so that time and effort are saved at both ends. **Thomas Edison, Inc., Dept. MH, West Orange, N.J. (Key No. 800)**

Hypodermic Syringe

A new line of hypodermic syringes is being introduced by Propper Manufacturing Company. A new formula borosilicate glass, designed to withstand maximum shock from quick, frequent and extreme temperature changes, is used in the new line to give the syringes greater durability. Known as "Shock-Proof," the new syringes are individually calibrated for precision dosage and the markings are acid etched and ceramic-fused for permanency. The Propper blue or sapphire plunger for easy dosage reading is a part of the new syringe.

A new package with a specially designed cut-out packing is used to reduce breakage in transit. The new "Shock-Proof" syringes are available in Luer metal tip and Luer lock tip in all sizes. **Propper Mfg. Co., Dept. MH, 10-34 44th Drive, Long Island City 1, N. Y. (Key No. 801)**

Combination Floor Cleaner

Vacuum polishing and vacuum cleaning are combined in one unit in the "Columbus" Suction Polisher and Cleaner. The suction polisher sweeps the floor clean of dust without throwing it into the air while polishing the floor. Dirt and grit removed by the brushes are drawn into a bag, similar to the action of a vacuum cleaner, while the brushes polish linoleum and wood floors. The

Columbus can be converted into a regular vacuum cleaner in a matter of seconds by attaching the Suction Cleaning Base which makes possible the use of vacuum dusting tools for use on furniture, venetian blinds and the like.

The cleaner also performs the regular scrubbing and drying process, operating with wet or dry vacuum pickup. The complete Columbus unit is being introduced into this country by **Columbus Combined Floor Polisher and Cleaners, Inc., Dept. MH, 333 E. 23rd St., New York 10. (Key No. 802)**

Grease Filter

A newly designed general utility filter for the kitchen has been introduced as the Grease Master. It consists of two large aluminum strainers filtering into each other. Twice the area of holes on the inside strainer is designed to cause agitation and thereby hasten filtering. A special filter paper is used between the two handled strainers. **Service Appliance Corp., Dept. MH, 1775 Broadway, New York 19. (Key No. 803)**

Mop Wringer Combination

A stainless steel pail with the efficient "Squeeze-Easy" wringer attached is a new mop wringer combination recently introduced. The pail is ruggedly constructed for long wear, is easy to clean and maintain and provides ample work space. It rolls smoothly on 2 inch solid casters, is leakproof and will not tip over. The streamlined wringer fits on the pail. It is of solid one-piece construction for lighter weight and greater strength. Non-squirting louvers make it impossible for water to splash out. A back floating plate slides forward to wring both large and small mops. **Market Forge Co., Dept. MH, Everett, Mass. (Key No. 804)**

Firedoor

Kayo insulation, a lightweight inorganic material, is used in the new firedoor which carries a one-hour fire rating from Underwriters' Laboratories. The new door is finished in handsome veneer so that it is attractive as well as functional. In the fire tests, the door formed an effective barrier against fire and smoke without becoming unduly heated on the "cold" side. Use of Kaylo insulation as the core material permits the manufacture of a standard sized firedoor which weighs only 90 pounds. The wood veneer bonded to the core does not shrink or swell and is resistant to moisture, rot and termites. **Owens-Illinois Glass Co., Dept. MH, Toledo 1, Ohio. (Key No. 805)**

Metal Washfountain Pedestals

All Bradley precast marble and stone Washfountains are now available with metal pedestals. The new pedestals are easier to handle because of their lighter weight and they give the fountains a new streamlined appearance. The pedestals are demountable, thus simplifying installation and maintenance. Internal mechanism is easily accessible because of this feature. **Bradley Wash-**

fountain Co., Dept. MH, N. 22nd & W. Michigan Sts., Milwaukee 1, Wis. (Key No. 806)

Address manufacturers for further information and prices — or use Reader's Service blank on page 248

Antiseptic Liquid Hand Soap

Chlorinated diphenyl methane compound, hexachlorophene, is used in a new antiseptic liquid hand soap developed by the West Disinfecting Company for the special use of doctors, nurses, food handlers and other workers in the hospital. The soap also contains lecithin, an emollient and skin-softener to help reduce skin irritations caused by frequent hand washing. It also increases the cleansing power of the soap. Known as West Antiseptic Soap, the product is said to have a cumulative antibacterial effect when used exclusively and often. **West Disinfecting Co., Dept. MH, 42-16 West St., Long Island City 1, N. Y. (Key No. 807)**

Lens Cleaner

A new scientific lens coating and cleaning agent is offered in Ozicote. The product is pressure-packed in small steel cylinders which fit into a patented chrome plated dispenser. It is designed to clean even the most stubborn dirt and grease from any type of lens and to fill in microscopic surface scratches and abrasions, leaving a lasting silicone film to help protect the surface of the lens. Ozicote is formulated so that all but the active ingredients evaporate quickly, permitting cleaning and polishing of lenses immediately. **Woodlets Incorporated, Dept. MH, Portland, Pa. (Key No. 808)**

Fruit Juicer and Shredder

A new line of juicers and food shredders has recently been introduced for use in the hospital field. The K & K fruit and vegetable juice extractor operates on the principle of hydraulic pressure. The maximum quantity of juice is extracted by this method and the pulp is retained in a bag for easy disposal. No electricity is required to operate the machine which has a squeezing pressure of more than 3000 pounds.

The K & K food shredder is simple to operate and is so constructed that food

is protected against contamination by working parts. Both devices are sturdily constructed and are easily cleaned and kept in sanitary condition. The food shredder is electrically operated from a ¼ h.p. engine. **Knuth Engineering Co., Dept. MH, 2617 N. St. Louis Ave., Chicago 6. (Key No. 809)**

Hartshorn Plastic Window Shade

Made of vinyl film, the new Hartshorn Plastic Window Shades are washable, colorfast, waterproof, insectproof, fire resistant and will not crack, fray or pinhole. The shades have been field tested and are available in white, ivory, beige and green. Sizes include 36 inch by 6 feet and 36, 42 and 48 inch by 7 feet. **The Stewart Hartshorn Co., Dept. MH, 250 Fifth Ave., New York 1. (Key No. 810)**

Shower Head

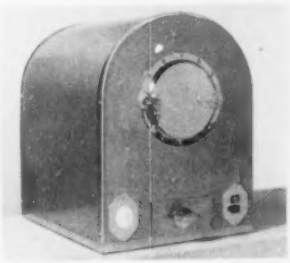
The new Kohler shower head is a multi-spray, self-cleansing unit, 3¾ inches in diameter. Each of the six clock-set plungers on the face delivers eight separate streams. Spray can be

altered to fine, normal and "flood" conditions by the easily accessible control handle on the sleeve. The exposed screwdriver type regulator permits quick adjustment of volume and the head can be set as desired by means of a swivel joint. **Kohler Co., Dept. MH, Kohler, Wis. (Key No. 811)**

Rust Inhibiting Paint

Certified Rust Inhibitor No. 425 is a new rust inhibiting oil base paint designed to provide both rust prevention and finish coat in one application. The paint can be applied to damp surfaces as well as to dry, penetrates rapidly through the rusted surface, instantly expelling moisture from beneath, is resistant to fumes, salt air and weather and may be applied to new metal or to that which has already rusted. The product withstands dry heat up to 500 degrees F. and is available in several colors. **United Laboratories, Inc., Dept. MH, 16801 Euclid Ave., Cleveland 12, Ohio. (Key No. 812)**

Glove Powdering Machine



A new small, compact Glove Powdering Machine has been introduced for the hospital or clinic that does not have a volume glove drying problem. The new machine completely powders surgical gloves at a rate of 40 gloves in five minutes. A timer switch can be set to control the degree of powdering, from four minutes for heavy powdering up to 10 minutes for thin powdering.

The new Bunn Glove Powdering Machine powders gloves inside and out, without turning. The drum is made of stainless steel, thus preventing glove discoloration. Excess powder returns to the powder drawer below the drum when the process is completed. **The John Bunn Corp., Dept. MH, 140 Ashland Ave., Buffalo 22, N. Y. (Key No. 813)**

Kengrip Wax

Kengrip Wax is a new non-slip product designed to reduce the hazards of slipping on floors. The product does not streak, is not tacky, does not collect dirt and wears evenly. The new product has a high carnauba wax content and a high total solids content. Its water-like consistency makes application easy and smooth and it leaves an attractive coating with a hard sheen. Kengrip Wax is available in 5 gallon and 55 gallon drums. **David E. Kennedy, Inc., Dept. MH, 58 Second Ave., Brooklyn 15, N. Y. (Key No. 814)**

Portable Typewriter

An office sized typewriter keyboard is a feature of the new Finger-Flite Champion portable Underwood typewriter. The machine has been redesigned in every detail from inner mechanism to the carrying case and has forty improved features for operating convenience. Spacing between the keys is the same as on the standard office Underwood. With its case, the new typewriter weighs slightly over 16 pounds. It is finished in non-glare gray with new gray keytops and maroon cylinder knobs and space bar. **Underwood Corp., Dept. MH, 1 Park Ave., New York 16. (Key No. 815)**

Address manufacturers for further information and prices — or use Reader's Service blank on page 248

Cloclamp Floor Cleaner

A new development in scientific floor maintenance is offered in the Cloclamp, designed to brush up the fine dust, dirt and soot which settle on exposed areas. Made of light weight aluminum, the Cloclamp is designed for use with an ordinary push-broom. A damp cloth is placed under the push-broom, the Cloclamp is slipped over the broom handle by squeezing the lever to release the friction grip, and slid down to the desired position. The folded edge of cloth is fastened in the two small clips and the broom is ready for use. By compressing the lever handle, the portion of the cloth under the broom handle is moved back and a clean area is in position ready for use. When the entire cloth has been used, it can be reversed and used on the other side. Dust-free cleanliness is ensured when the Cloclamp technic is properly employed. **Walter G. Legge Co., Inc., Dept. MH, 101 Park Ave., New York 17. (Key No. 816)**

Oxygen Valve and Flowmeter

Two new items have been announced for use with piped oxygen distribution systems. One is the compact, precision built Control Valve No. 4901 which provides for a sensitive control of oxygen from 1 to 15 liters per minute and a flood valve for flushing tents when open to full capacity. The Control Valve forms a positive shut-off when closed.

The Schrader Flowmeter No. 4895 is the other item. It snaps onto the Schrader Control Valve and locks in place, thus eliminating the necessity for threaded connections. Two "O" ring plugs on the Control Valve form a pressure-tight connection. The Flowmeter can thus be applied or removed easily with one hand. White markings on a black face make it easy to read and calibrations range from 1 to 15 liters with half liter markings. It is not necessary to remove the Flowmeter when flushing tents since it does not interfere with the full flow of the Control Valve. **A. Schrader's Son, Div. of Scovill Mfg. Co., Inc., Dept. MH, 470 Vanderbilt Ave., Brooklyn 17, N. Y. (Key No. 817)**

Improved Time-Master

Time-Master dictating machines and accessories have been improved in several respects. Magnesium is used to make outer casings, base plates and internal parts, thus reducing the weight of the machine which is completely portable. The new hand-held microphone is a complete control center for the user. A turn of the switch on the microphone permits dictation or instant playback, as desired. The tilting head permits comfortable dictation with the hand held in a natural position.

Of particular interest to hospitals are the new non-directional lapel microphone approximately 2 inches in diameter which has 25 feet of microphone cable for special recording, and the new chest microphone with plate and neck band and tilting head permitting high-fidelity recording. The chest plate may be used as a base if the microphone is used on a desk. The executive desk microphone is designed for high-fidelity pick-up,

natural voice reproduction and attractive appearance. The new seamless Memobelt recording medium is made of extruded plastic. **Dictaphone Corp., Dept. MH, 420 Lexington Ave., New York 17. (Key No. 818)**

Electric Hand Dryers

The complete line of Sani-Dri electric hand and hair dryers has been improved to provide shorter drying time. A new, faster-drying heating element and a new, smaller oval nozzle which produces a more concentrated, quicker drying air stream are features of the redesigned line. The drying nozzle is obtainable in either swivel or fixed position.

Another feature of the improved machines is an instant starting, heavy duty switch. The new push-button switch is available on the semi-recessed wall model in place of the recessed foot switch, if desired. A simplified timing device has also been introduced in the new models and the machines are equipped with a sealed, ball-bearing motor requiring no lubrication. The improved features of the new machines are interchangeable with the parts in old machines purchased since 1929. **The Chicago Hardware Foundry Co., Dept. MH, North Chicago, Ill. (Key No. 819)**

Radiation Counter

A new monitor for checking all types of electro-magetic radiation found in clinics, hospitals and laboratories has recently been introduced. The new count rate meter is battery operated and uses a thin mica end window probe with the density of only 1.4 milligrams per square centimeter. The window may be used for monitoring alphas as well as betas and gamma rays. Known as Model 2611, the instrument has a watertight case and the probe mounts in the handle to permit one hand use if desired. Headphones are also furnished for listening to the indication. **Nuclear Instrument & Chemical Corp., Dept. MH, 229 W. Erie St., Chicago 10. (Key No. 820)**

Aluminum Windows

A built-in hopper vent is a feature of the new double-hung aluminum windows recently introduced. This feature permits controlled ventilation at the seating level when the sash is raised. The inswinging hopper vent is an integral part of the frame, giving maximum structural strength and rigidity.

The hopper vent is equipped with white bronze satin finish hinges, anchored in reenforced jamb blocks and with concealed sliding friction arms of stainless steel. Monel or 18-8 stainless steel weatherstripping is provided. The window carries overhead concealed clock spring balances with stainless steel tapes, which can be either inside bead or outside compound glazed. The lower sash is provided with a continuous lift rail. The windows are custom-built to specified sizes up to a maximum width of five feet and a maximum height of 10 feet.

Another Sterling Window design is the hospital-type sill, which provides no-draft ventilation when the lower sash

is raised 1¼ inches. **Sterling Windows, Inc., Dept. MH, 369 Lexington Ave., New York 17. (Key No. 821)**

Address manufacturers for further information and prices — or use Reader's Service blank on page 248

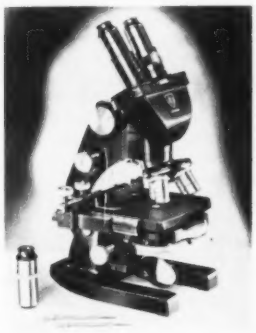
Laboratory Chairs

Two new chairs developed especially for the comfort of those working in the laboratory have recently been introduced. The chairs are designed to fit workers of varying heights since they have automatic height adjustment. They have a strong, single pedestal which can be instantly adjusted by raising the seat. The ball bearing clutch grips and holds without danger of slipping back. The seat is as easily lowered as raised.

The chairs are sturdily constructed with broad steel bases finished in baked-on light gray enamel resistant to fumes and abrasion. They are of posture design and are built for long wear. Style B-16280 has a wood saddle seat 16 inches wide which is finished in clear varnish and it has height adjustments from 18 to 26 inches. The gray enameled metal back rest is adjustable for height and angle. Large floor glides finish the chair but casters can be supplied if desired. Chair B-16285 has a height range of 17 to 22 inches with a revolving seat covered in brown fabricoid and the adjustable back rest is padded with sponge rubber. The chair is supplied with casters. **Boder Scientific Co., Dept. MH, 719 Liberty Ave., Pittsburgh 22, Pa. (Key No. 822)**

AO Phase Microscope

Phase microscopy permits the study of living organisms as well as other transparent materials of inherently low contrast. The new series of AO Spencer Phase Microscopes has monocular and binocular bodies and incorporates many improvements over original models introduced by the company. Phase turret condensers with interchangeable annular diaphragms are now available in hardened steel, centerable mount. The mount is firmly held so that it cannot tilt. Long focus annular diaphragms are also offered. The control knobs have been lowered to a more comfortable



position nearer the stage. The ball bearing fine focusing adjustment is responsive to the lightest touch and is accurate throughout its entire range of travel.

Several other new technical features make the line of particular interest. Overall weight has been reduced by use of an aluminum arm and body but the instruments are engineered for increased rigidity and long life. **American Optical Co., Scientific Instrument Div., Dept. MH, Buffalo 15, N. Y. (Key No. 823)**

Hone for Hypodermic Needles

Hypodermic needles can be quickly and easily sharpened with the new Hypo-Hone. It is a simple device in two parts, precision machined from brass and cold rolled steel, nickel-silver plated to resist perspiration and other acids. In use, the barrel is inserted into a plunger on which the needle hub is mounted. The needle is adjusted until it barely protrudes through the hole in the bevel at the end of the barrel. Ball friction points on the plunger prevent rotation of the needle in the holder while the beveled surface of the assembly is held flat on the fine grained special stone and moved back and forth a half dozen times.

Points can be restored to dull or damaged needles in a minimum of time and needles can be kept serviceable for months through use of the Hypo-Hone. It is adapted to sharpening the wide variety of hypodermic needles used in the hospital and needles may be honed many times for efficient service. **John Gould Curtis, Dept. MH, P.O. Box 21, North Grafton, Mass. (Key No. 824)**

Portable Tape Recorder

The Ekotape Pla-mate is a new portable tape recorder having 3¾ inch per second tape speed and twin track recording which gives two hours of playing time with a 7 inch reel or one hour playing time with a 5 inch reel. The unit is small, light in weight and easy to handle. It is easily operated with one central control selecting tape speed and direction. A separate record-playback control eliminates the possibility of accidental erasing. It comes complete with microphone, cord and one 5 inch reel of tape in an attractive carrying case. **Webster Electric Co., Dept. MH, Racine, Wis. (Key No. 825)**

X-Ray Processing Unit

Three units are contained in one in the new Keleket Deluxe Stainless Steel 3 in 1 Processing Unit. A large refrigerated developing tank, a large non-refrigerated wash section and a spacious timer-controlled film dryer are combined in one attractive unit with a stainless steel back bar. On the back bar is a thermo mixing valve, a 14 by 17 inch fluorescent illuminator, a Wratten safe light, recessed timer shelf and separate shut-off valves for developing tank and wash section.

The 14 by 17 inch refrigerated developing tank consists of a five-gallon developing section, a five-gallon hypo section and an 18 gallon rinse section. The unit may be air or water cooled. The wash section has a 35 gallon capacity and accommodates 18 films, 14 by 17 inches each. The bottom of the tank is rounded for easy cleaning. The film drying section also accommodates 18 films and the timer permits efficient, economical operation. **The Kelley-Koett Mfg. Co., Dept. MH, Covington, Ky. (Key No. 826)**

Darkroom Viewlight

Specifically designed for wet film viewing of x-ray film in the darkroom, the new single-section x-ray darkroom viewlight introduced by Westinghouse is constructed of special rust-resistant stainless steel throughout, coated with Durofilm plastic for corrosion resistance. It is said to meet the requirements of the standard Army-Navy salt spray test.

Two-tube fluorescent illumination in the new viewlight is controlled by "on" and "off" buttons for instantaneous operation. A high degree of uniform light intensity is provided over the entire viewing surface. Stainless steel top brackets support standard x-ray film hangers and a plastic-coated tray at the base catches any liquid dripping from wet film. **Westinghouse Electric Corp., Dept. MH, 306 Fourth Ave., Pittsburgh 30, Pa. (Key No. 827)**

Address manufacturers for further information and prices — or use Reader's Service blank on page 248

Maintenance Utility Cart

Maintenance or housekeeping duties can be facilitated with the new institutional cleaner's utility cart No. 2 recently developed. A light weight, highly flexible cart for general use, it is made of metal tubing with heavy gauge galvanized metal shelves. Attached to the end is a large bag which can be easily emptied and laundered after use.

The cart has a large general section with holders for 6 brooms or cleaners and 2 brushes and three small shelves for carrying attachments, cleaning fluids, soaps, rags, paper towels, toilet and bathroom requirements, plumbing and electrical supplies and tools or other equipment desired. The cart is inexpensive, is mounted on rubber wheels and has rubber bumpers. It is 41½ inches high, 34 inches long and 24 inches wide. **Gennett & Sons, Inc., Dept. MH, Richmond, Ind. (Key No. 828)**

Dishwasher Heating

New Chromalox electric heating elements are now available for the line of Kewanee dishwashers. Of the immersion type, the elements are designed for use in installations where gas is not available or where electric heating is more practical. The new elements are 230 V, AC or DC, are adaptable to both the standard dishwashers and the pre-wash machines, and are equipped with thermostatic control. **Kewanee Industrial Washer Corp., Dept. MH, Kewanee, Ill. (Key No. 829)**

Photomicrography

A new photomicrographic device, known as the Orthophot, has been developed to provide facilities for photomicrography, photomacrography, micro-projection and laboratory, clinical and general photography, photocopying, microfilming, x-ray photocopying and photoenlarging. The apparatus can be used with any standard microscope and has three basic units: a base with permanently aligned built-in light source and built-in color filters; a self-aligning reflex camera with precision focusing device, automatic Rapax shutter and attached sensitive photoelectric exposure meter, and a vertical column assembly with counterbalanced elevating device for camera. The reflex camera itself is detachable and can be used on a standard tripod or hand held for all forms of scientific or general photography. Light source, camera and vertical column are available separately for combination with existing equipment. **Silge & Kuhne, Dept. MH, Box EA, 153 Kearny St., San Francisco 8, Calif. (Key No. 830)**

Pharmaceuticals

Cortone

The Merck brand of cortisone, Cortone, will be made generally available on or about November 1 through distributors, hospitals, institutions and pharmacies for use by the physician in his daily practice, according to a report from Merck & Co., Inc. Meanwhile, the announcement continues, physicians may continue to obtain Cortone from hospitals, and patients need not be hospitalized except at the physician's discretion. **Merck & Co., Inc., Dept. MH, Rahway, N. J. (Key No. 831)**

Simplastic

Simplastic is described as "a simply prepared, standardized and relatively stable thromboplastin extract for estimation of prothrombin time." It is designed to eliminate sources of error in making prothrombin time estimations and the procedure is so simplified that the tests can be performed in approximately 15 minutes by a nurse or assistant. It is said to make the control of anticoagulant therapy easily available to every physician and hospital. **Chilcott Laboratories, Dept. MH, Morris Plains, N. J. (Key No. 832)**

Furacin Ophthalmic

Furacin Ophthalmic Liquid and Furacin Ophthalmic Ointment are two new preparations for the treatment or prophylaxis of external bacterial infections of the eye. The liquid contains Furacin brand of nitrofurazone 0.02 per cent in an aqueous vehicle. The ointment contains Furacin 1 per cent in a petrolatum type vehicle. **Eaton Laboratories, Inc., Dept. MH, Norwich, N. Y. (Key No. 833)**

Aleudrin Hydrochloride Tablets

Aleudrin Hydrochloride Tablets, 10 mg., are offered for the symptomatic treatment of bronchial asthma. They are supplied in bottles of 50 and 500 tablets. **The National Drug Co., Dept. MH, 4663 Stenton Ave., Philadelphia 44, Pa. (Key No. 834)**

Color Coded Labels

Color coded labels for its penicillin products have been developed by The Wm. S. Merrell Company. Each dosage form of penicillin has its own individual color. Thus selection of dosage form is expedited and the possibility of error by the nurse or other personnel in preparing a given dosage is minimized. **The Wm. S. Merrell Co., Dept. MH, Cincinnati 15, Ohio. (Key No. 835)**

Bevidox Concentrate Capsules

Bevidox Concentrate Capsules each contain the equivalent of 25 micrograms of crystalline vitamin B_{12} and are offered for experimental clinical use in the treatment of macrocytic anemias other than pernicious anemia and for other clinical conditions for which vitamin B_{12} may be beneficial. They are supplied in bottles of 100. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 836)**

Vycom B Plus

Vycom B Plus Tablets contain high potency B complex with vitamin C for oral administration. The orange sugar coated tablets contain fresh yeast and vitamin C in addition to B complex vitamins. **Bristol Laboratories Inc., Dept. MH, 630 Fifth Ave., New York 20. (Key No. 837)**

Cholan-HMB With Phenobarbital

Cholan-HMB with Phenobarbital combines dehydrocholic acid-Maltbie, homatropine methylbromide and phenobarbital in tablet form. It is designed to serve as comprehensive therapy in one tablet against the pathologic mechanisms involved in the hepato-biliary syndrome. The product is supplied in bottles of 100, 500 and 1000 tablets. **Maltbie Laboratories, Inc., Dept. MH, Newark 2, N. J. (Key No. 838)**

Tubadil

Tubadil is a preparation for the relief of muscle spasticity. It is a repository injection of d-tubocurarine for securing prolonged relaxation of voluntary muscle in spasm whether pain is present or not. It is supplied in 5 cc. multiple dose vials. **Endo Products Inc., Dept. MH, Richmond Hill 18, N. Y. (Key No. 839)**

Terramycin Elixir

Terramycin is now available in elixir form and is being released under the trade name Terrabon. Each teaspoonful of the elixir contains 250 mg. of terramycin, the equivalent of one regular 250 mg. capsule. It is presented in a cherry-mint flavored liquid which simplifies administration to children and to geriatric patients. The product is supplied in a vial containing 1.5 gm. of terramycin and a bottle containing 1 fluid ounce of a specially flavored and buffered diluent. When compounded the terramycin elixir can be stored for at least two weeks at room temperature without appreciable loss of potency. **Chas. Pfizer & Co., Inc., Dept. MH, 630 Flushing, Brooklyn 6, N. Y. (Key No. 840)**

Address manufacturers for further information and prices — or use Reader's Service blank on page 248

Product Literature

• Through the medium of a new educational sound slidefilm hospital administrators, purchasing agents, operating room supervisors, nurses and other personnel can take a trip through the Weck factory and learn details of the manufacture of precision surgical instruments. The slidefilm is available for showing in the hospital, through Weck salesmen who have a portable projector and sound reproducer, and is sponsored by Edward Weck & Co., Inc., 135 Johnson St., Brooklyn 1, N. Y. Entitled **"Sixty Years of Leadership,"** the film opens with an exterior shot of the Weck plant and takes the viewer on a tour, via the camera, through various departments, under the direction of Frank Wilmarth, Weck sales manager. **(Key No. 841)**

• The complete line of **Witt Corrugated Cans** is described and illustrated in a new 32 page General Catalog No. 63 issued by The Witt Cornice Co., 2144 Winchell Ave., Cincinnati 14, Ohio. Results of laboratory tests, standards of quality, sizes, weights, capacities and shipping information on the various items in the line are given. Products covered include heavy duty cans and pails, underground garbage receivers, mopping pails, refuse cans, special cans and a new universal can dolly. **(Key No. 842)**

• A literature kit on the **IBM electric typewriter** is available from International Business Machines Corp., 590 Madison Ave., New York 22. Included is the "IBM Typing Guide" describing operative features of the IBM electric typewriter and discussing principles of good typing, "The Latest Fashion in Typing" and "The History of IBM Electric Typewriters" as well as a chart contrasting several features of manual and IBM electric keyboards. **(Key No. 843)**

• A new "America Short" film, **"House of Mercy,"** has been released by RKO Pathe, 625 Madison Ave., New York 22. The film is based on the importance of the community hospital and tells a dramatic story of how it serves, in a 15 minute sequence. "House of Mercy" was prepared for use by local motion picture houses as a "short" and post card mats and press books to be used by the hospital as publicity in urging its community to see the picture when it is run are available. **(Key No. 844)**

• An 8 page illustrated folder has been released by the Canton Stoker Co., Canton 1, Ohio, giving descriptive and technical information on the new **Canton Turbo-Air oven-fire air system** which is designed for maintaining the maximum combustion of coal fuels and the elimination of smoke. **(Key No. 845)**

• How to select labor-saving products to cut maintenance costs is discussed in the new **"Modern Maintenance"** catalog recently issued by Hillyard Chemical Co., St. Joseph, Mo. The 48 page, 2 color book uses text and illustrations to show the uses of more than 100 specialized products and the results obtained with them. The products include cleaners, waxes, seals, finishes, dressings, deodorants, antiseptics and germicides as well as cleaning equipment ranging from squeegees to machines for cleaning and polishing. **(Key No. 846)**

• The 1951 edition of the **Lowerator Dispenser Catalog** is now available from the American Machine & Foundry Co., 485 Fifth Ave., New York 17. New models and sizes of the Lowerator storage and automatic dispensing unit for dishes are illustrated and described and installation pictures are included showing the new Lowerator chassis units installed in refrigerated cabinets. Complete lists of racks and china sizes and opening and chassis dimensions are shown in tables with the models described pictured on facing pages. **(Key No. 847)**

• A new fully illustrated **Catalog and Handbook** has been issued by Coyne & Delany Co., 834 Kent Ave., Brooklyn 5, N. Y., covering the use and installation of flush valves. The catalog covers installation details, parts identification, piping design and a manual of charts and instructions. Blue prints, details and specifications are given covering every type of installation and special recommended applications for specific uses are illustrated in this complete Delany Flush Valve Catalog No. 49. **(Key No. 848)**

• **"Awning Windows for Hospitals"** is the title of a technical folder issued by the Gate City Sash & Door Co., Ft. Lauderdale, Fla. Containing specifications for the complete awning window, hardware specifications and drawings showing typical details, the folder also discusses advantages of awning windows in the hospital. The folder has been awarded the Certificate of Merit in the recent 1950 Product Literature Competition sponsored by the American Institute of Architects and the Producers' Council, Inc. **(Key No. 849)**

• A new circular, **"Burnitol for Use in Hospitals and Sanatoria,"** has been published by Burnitol Mfg. Co., 32 Sullivan Square, Boston 29, Mass. Sputum cups, fillers, holders and flasks are described and illustrated and the various types and classes of the Federal Specifications UU-C-821B which apply to each cup are illustrated. The folder states that Burnitol products meet Federal Specifications for protection against cracking or leaking as well as for weight and gauge of paperboard used. **(Key No. 850)**

• Two folders on **G-E Germicidal Tubes** and their use for disinfection of air in hospitals have been released by the General Electric Co., Nela Park, Cleveland 12, Ohio. One folder, "G-E Germicidal Tubes for Air Disinfection in the Hospital," features applications of the tubes in the various departments of the hospital with information on the principle of upper air disinfection, importance of proper devices and the types of devices available. Some results of germicidal installations in hospitals are discussed. The second folder, "Air Sanitation With G-E Germicidal Tubes," is a treatise in editorial style giving factual data on germicidal ultraviolet, air contamination, air sanitation, spores in the air and other information which should be of interest to hospital and medical personnel. **(Key No. 851)**

• The second in a series of films on endocrinology has been made by Sturgis-Grant Productions, Inc., for Schering Corporation, Bloomfield, N. J. Entitled **"The Male Sex Hormone,"** the film presents the physiology and the clinical aspects concerned with hormone interaction in the male. It will be made available to medical schools and colleges throughout the country through the Medical Service Department of Schering. The film runs 24 minutes **(Key No. 852)**

• **"New Ideas on Plant Sanitation and Maintenance"** is the subject of a booklet by J. Lloyd Barron, C. E., Sanitary Engineer and Manager, Sanitation Dept., National Biscuit Co., New York, and released by G. H. Tennant Co., 2530 N. Second St., Minneapolis 11, Minn. The 16 page booklet includes specific answers to questions on maintenance and sanitation, is fully indexed and lists commonly asked questions with reference pages indicated where the answer is provided. **(Key No. 853)**

• How your institution can be protected against damage which results from electric power failures is discussed in a booklet, **"When Power's Off . . . You're Safe!"** recently released by D. W. Onan & Sons Inc., Minneapolis 5, Minn. Known as the Standby Folder, A-277, it presents full information on the new Onan Standby Generator. **(Key No. 854)**

• The new line of **National Unit Heaters** is described in **Catalog No. 75** recently published by The National Radiator Co., Johnstown, Pa. Printed in two colors, the catalog gives full information on selecting size and type of unit heaters and presents operating quietness level table, basic steam and hot water capacities of units and output tables for steam pressures other than normal and for varying hot water flows and temperatures. **(Key No. 855)**

Address manufacturers for further information and prices — or use Reader's Service blank on page 248

• **"How to Simplify Your Files and Filing Systems"** is the title of a new 40 page booklet issued by Remington Rand Inc., 315 Fourth Ave., New York 10. The booklet charts the life cycle of a file, beginning with the origin of a record, progressing through indexing, filing, charge-out and retention or transfer of the record, including the use of microfilming equipment. **(Key No. 856)**

• **The Precision Dubnoff Metabolic Shaking Incubator** for metabolic studies is described in **Bulletin No. 675** recently released by Precision Scientific Co., 3737 W. Cortland St., Chicago 47. The bulletin gives comprehensive information on the outstanding features and the application of this and other instruments and also lists reference material. **(Key No. 857)**

Book Announcements

Anson, "An Atlas of Human Anatomy," 518 pp., $11.50. Freeman, "Public Health Nursing Practice," 337 pp., $3.50. Shanks and Kerley, "A Text-Book of X-Ray Diagnosis," 2nd Ed., Vol. III, 830 pp., $18. Sodeman, "Pathologic Physiology: Mechanisms of Disease," 808 pp., $11.50. Sweet, "Thoracic Surgery," 345 pp., $10. **W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa. (Key No. 858)**

Beyer, "Pharmacological Basis of Penicillin Therapy," 200 pp. Diethelm, "Treatment in Psychiatry," 2nd ed., 574 pp., $8.50. Rankin and Graham, "Cancer of the Colon and Rectum," 2nd ed., 439 pp., $7.50. **Charles C. Thomas, Publisher, 301 E. Lawrence Ave., Springfield, Ill. (Key No. 859)**

Suppliers' News

George G. Rups, Assistant General Sales Manager and Sales Promotion Manager of the **American Laundry Machinery Co., Cincinnati 12, Ohio,** died suddenly in Boston, Massachusetts, on October 6 while attending the American Institute of Laundering convention. Mr. Rups had been with the American Laundry Machinery Company since 1915 and was well known in the hospital field.

Armour and Company, Union Stock Yards, Chicago 9, announces that the administrative offices of Armour Laboratories, the pharmaceutical division of the company, have been moved to 520 North Michigan Ave., Chicago 11.

Gilbert Hyde Chick Co., 821 75th Ave., Oakland 3, Calif., manufacturer of orthopedic equipment, announces the opening of a Southern Branch Office in the First National Bank Bldg., Elberton, Ga., on September 1. The new office will be under the supervision of **Zack Rogers,** General Sales Manager, and will serve the South and East.

Electro-Medical Laboratory, Inc., manufacturer of scientific electrical equipment, announces removal of its offices from Holliston, Mass. to **South Woodstock, Vermont.**

Lakeside Manufacturing Co., manufacturer of hospital utility carts, announces removal of its offices from 734 Virginia St., Milwaukee 4, to **1977 S. Allis St., Milwaukee 7, Wis.**

The Robot Laundry Machinery Co., manufacturer of the Robot Fully Automatic Washer, has been taken over by L. B. Smith, Inc., Camp Hill, Pa. and removed from its former location in Torrance, Calif. A new sales and service organization has been set up which is known as **Robot Laundry Machinery Sales, Division of The Wolf Company, Chambersburg, Pa. E. R. Leis** will be in charge of marketing under the new arrangement.

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it. If you read the hospital copy or the administrator's copy of The MODERN HOSPITAL or for any other reason do not wish to clip the magazine itself, upon request we shall be glad to send you regularly a reprint of this department containing the coupon.

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Editor, "What's New for Hospitals"

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- ☐ 829 Dishwasher Heater
- ☐ 830 Photomicrography
- ☐ 831 Cortone
- ☐ 832 Simplastic
- ☐ 833 Furacin Ophthalmic
- ☐ 834 Aleudrin Hydrochloride Tablets
- ☐ 835 Color Coded Labels
- ☐ 836 Bevidox Concentrate Capsules
- ☐ 837 Vycom B Plus
- ☐ 838 Cholan-HMB with Phenobarbital
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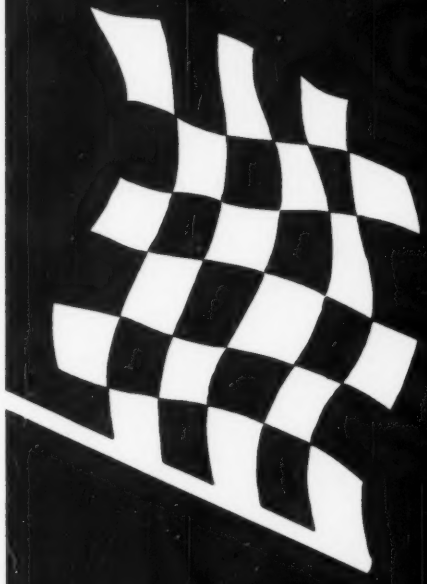

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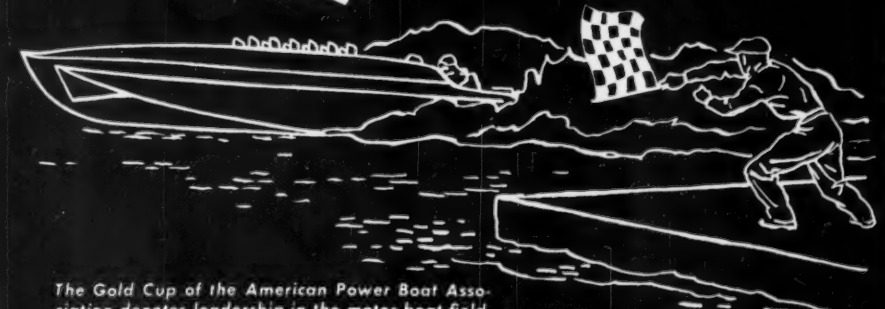

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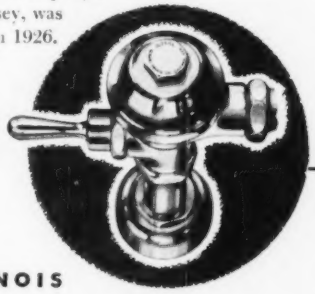

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